**UNI Student Health Clinic** Phone 319-273-2009 / Fax 319-273-7030
**UNI Counseling Center** Phone 319-273-2676 / Fax 319-273-7030

**Student Health Center**
1227 W 27th St
Cedar Falls, IA 50614

# Authorization to Release Protected Health Information

**Patient Information:**

Name (Legal/Maiden/Other):________________________________________________

Phone Number:______________________ Date of Birth:__________________ UNI ID Number:____________________

Local Address:_________________________________ City:______________ State:________ Zip:__________

**The parties I have indicated below, I hereby authorize University of Northern Iowa**

☐**Student Health Clinic to:** ☐ **Obtain from** ☐ **Exchange with** ☐ **Release to**
☐**Counseling Center to:**

Name of Individual/Agency/Organization: ________________________________________________

Address: _________________________________ City:______________ State:________ Zip:__________

Phone: ____________________ Fax:______________________

**the following information:**

☐Provider Evaluations ☐Lab Results ☐Test Results ☐Medication History ☐Appointment Attendance

☐Mental Health Treatment Summary ☐Recommendations ☐Other:________________________________

**for the purpose of:**

☐Medical/Medication Evaluation ☐Continuing Care ☐Coordination of Treatment ☐Family Involvement ☐Legal Purposes

☐Academic Considerations ☐SSA/Disability ☐Insurance Coverage ☐Personal Use ☐Other________________________

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW**

I **specifically authorize** the release of confidential information relating to:

☐**Mental Health** ☐**Substance Abuse**** ☐**HIV/AIDS information** **Signature:________________________________**

**Only the patient, regardless of age can authorize release of substance abuse information

- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken, by giving written notice to UNI Student Health Clinic and/or UNI Counseling Center.
- I understand that I have the right to inspect the disclosed information.
- I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure. Once information is disclosed, it may no longer be protected by federal/state law and may be re-disclosed.
- I understand that refusal to sign this authorization will not affect my ability to receive treatment at the UNI Student Health Clinic and/or UNI Counseling Center.
- This authorization will remain in effect for one year from the date signed, unless another date is specified: _________________

________________________________________________________________

**Signature of Patient or Parent/Legal Guardian** **Date**

________________________________________________________________

**Signature of Witness** **Date**

**PROHIBITION OF REDISCLOSURE**

This information is protected by Chapter 228 and/or 141 of the Iowa Code or Federal Regulation 42 CFR Part 2, which prohibits further disclosure without the written consent of the patient and UNI Student Health Clinic and/or UNI Counseling Center or as otherwise permitted by such law and/or regulation. A general authorization for the release of information is not sufficient for these purposes. Unauthorized disclosure is unlawful and civil damages and/or criminal penalties may apply. This authorization is intended to comply with HIPAA and Iowa law.

**Office Use Only:** Notification to Student Health Clinic and/or Counseling Center Mental Health Provider

Provider Name:________________________________________________ Approve: ☐Yes ☐No

Mental Health Provider Signature (required):________________________________ Date:________________

Released by:______________________ Date:__________ Method:☐Fax ☐Mail ☐Pick-up ☐Other:________________ ☐ID verified