UNI Student Health Clinic
Phone 319-273-2009 / Fax 319-273-7030

UNI Counseling Center
Phone 319-273-2676 / Fax 319-273-7030

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