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BOWLING GREEN STATE UNIVERSITY

PATIENT/EMPLOYEE AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

1. Name of Patient/Employee

Name: _____

DOB: _____ Job Title: _____

Home Address: _____

_____

Work Address: _____

_____

Telephone: (H) _____ (W) _____

Fax: (H) _____ Email: _____

2. Purpose of the Disclosure

The purpose of the disclosure I have authorized above is –

☐ To assist the University in processing my request for an accommodation and/or to make a determination of whether I have a "disability."

☐ To honor my request. I have initiated this authorization and I do not elect to provide a statement of my purpose.

☐ Other _____
(specify)

I understand that the information released by this authorization may be re-released by the University and may not be protected by federal or state privacy laws including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

BG Campus
38 College Park Office Building
Bowling Green, OH 43403-0185

Phone 419-372-8495
Fax 419-372-8496
Email: access@bgsu.edu
www.bgsu.edu

Firelands Campus
105 George Mylander Hall
One University Drive
Huron, OH 44839-9719

3. Authorization and Release

I, the above named Patient/Employee, do hereby authorize my healthcare provider and/or custodian of my health records:

_____

(Name of doctor or other healthcare provider or the holder of health records)

to release the healthcare records and information checked in the boxes below to the University Representative named in paragraph No. 4 of this document.

- The healthcare records and information are for treatment provided to:

  ☐ myself

  ☐ other _____
  (specify relationship)

- The records and information authorized by me for release relate only to treatment/consultation provided during the following period of time:

  ☐ From: _____ To: _____

  ☐ No time limitation

- The healthcare records and information I am authorizing for release to the University Representatives are as follows:

  ☐ Progress Notes (including notes on diagnosis and prognosis)

  ☐ Laboratory/Test Reports ☐ Operative Reports

  ☐ Consultative Notes/Reports ☐ Office Visit Records

  ☐ Radiology Reports/X-Rays/other images and related reports

  ☐ Other (specify): _____

  ☐ My entire health record, including but not limited to, all of the above *and* all information regarding medication, treatment, referrals, and records from other providers.

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- I give specific authorization to discuss the following health matters with the University's Representative

  ☐ HIV Test Results ☐ Documentation of AIDS Diagnosis

  ☐ Drug/Alcohol abuse treatment records

  ☐ Other (specify): _____

- I authorize all of the healthcare records and information I have authorized for disclosure above to be released in the following ways:

  ☐ Written/hard copy ☐ Verbal ☐ Fax

  ☐ Electronic mail ☐ Any electronic medium

  ☐ All of the above

  I RELEASE THE HEALTHCARE PROVIDER OR RECORDS CUSTODIAN FIRST MENTIONED ABOVE IN THIS PARAGRAPH 3 FROM LEGAL RESPONSIBILITY OR LIABILITY ARISING OUT OF ANY DISCLOSURE OF THE ABOVE DESCRIBED HEALTH RECORDS AND/OR INFORMATION THAT IS MADE IN RELIANCE ON THE AUTHORIZATION CONTAINED IN THIS FORM.

4. University Representative

The person(s) identified below is [are] the University Representative[s] authorized by me to receive and use the records and the information that I have authorized for disclosure above:

Name: _____

Title: _____

Address: _____

_____

Telephone: _____ Fax: _____

Email: _____

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5. Revocation of Authorization

I understand that I may revoke my authorization at any time. If I withdraw my authorization, my health records and information may no longer be used for the reasons stated above; nor may those records be used for any other reason not authorized by me. I also realize that any disclosure previously made with my authorization and prior to my revocation cannot be taken back. I understand that the University may have already taken an action in reliance on such records and information previously received.

I may only revoke this authorization in writing and the revocation must be sent to the University Representative designated in paragraph No. 4 above.

6. Expiration Date of Authorization

Unless revoked by me earlier or unless I specify an alternate date in this paragraph 6, this authorization expires in one (1) year from the date of my signature below:

_____.
(alternate date)

7. No Effect on the Availability of Treatment

I understand that my treatment from the healthcare provider first mentioned in paragraph 3 above will not be conditioned on my failure to sign or complete this form.

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8. Release and Signature

THIS IS AN IMPORTANT LEGAL DOCUMENT.
PLEASE READ IT CAREFULLY BEFORE SIGNING.

I understand this authorization is voluntary and that I may refuse to sign it. A photocopy of this signed authorization will be as valid as the original.

_____ _____
Signature of Patient/Employee or Patient/Employee Representative — Date

_____
Printed Name

If other than Patient/Employee, explain relationship and authority to act for that individual:

_____

_____

_____

-FOR UNIVERSITY USE ONLY-

A copy of this signed authorization was provided to the Patient/Employee or his/her representative by:

_____

_____

_____

Date

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