# Delaware State University

**Campus Health Services**
**(302) 857-6393**
**Fax: (302) 336-9896**

## REQUEST FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date: _____

Current Address: _____

Date of Birth: _____ Contact Number _____

DSU ID# _____

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I hereby authorize Campus Health Services to **(please check)** ____Obtain from ____Release to

Name _____

Address _____

Telephone _____ Fax _____

Requested Information _____

_____

_____

Reason for Disclosure _____

**I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).** Only such records and/or information believed necessary for the purpose expressed above shall be released.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this request, I must do so in writing and present my written revocation to Campus Health Services. I understand that the revocation will not apply to information that has already been released in response to this request. This request will expire 120 days from the date it is signed.
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure treatment.

Signature_____ Date_____

Print Name: _____

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**ID VERIFICATION** _____ YES _____ NO
Records were _____ MAILED _____ FAXED _____GIVEN to Authorized Entity/Individual listed above by:

Campus Health Staff _____ Date_____