HIPAA Privacy Office
Babbitt Administration
Building 51, Room 100
P.O. Box 4116
Flagstaff, AZ 86011-4116
928-523-6347

NORTHERN ARIZONA UNIVERSITY

Authorization for Use or Disclosure of Health Information

I authorize _____ (name of NAU Department, clinic, individual, etc.) to disclose the following information from the health records of:

First Name: _____ Last Name: _____

Date of Birth: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

I authorize the following persons (or class of persons) to receive my Protected Health Information (PHI):

First Name: _____ Last Name: _____

Date of Birth: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

INFORMATION TO BE RELEASED (check as applicable):

Allergy Records	Consultations	Developmental/Behavioral
Discharge Summary	Drug/Alcohol Treatment	Genetic Testing
HIV/AIDS	History and Physical	Hospital Records
Immunizations	Surgical Reports	Laboratory Reports
Prescriptions	Psychiatric	Sexual Assault
Sexually Transmitted Disease		Treatment or Tests
X-Ray Reports	Other Communicable Disease	

Other (Specify): _____

OR

ENTIRE RECORD **excluding** the following (CHECK as applicable):

Sexually Transmitted Disease
HIV/AIDS
Other Communicable Diseases
Genetic Testing
Developmental/Behavioral Health Care/Psychiatric Care
Treatment of Alcohol and/or Drug Abuse
Information about Child Abuse/Neglect

FOR THE FOLLOWING DATE(S) OF SERVICE:

From (MM/DD/YYYY): _____ To (MM/DD/YYYY): _____

PURPOSE FOR THE DISCLOSURE (Check applicable categories):

Treatment Research Medical Hardship Waivers Legal Investigation or Action

Insurance Eligibility/Benefits Other (Specify): _____

EXPIRATION DATE:
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the NAU HIPAA Privacy Officer at P.O. Box 4116, Flagstaff, AZ 86011. Unless revoked, this authorization will expire on the following date or event:

_____

*Note: If this authorization is for a use or disclosure of PHI for research, "end of research study," "none" or similar language is sufficient.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this authorization.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page1) to use or disclose my health information in the manner described above.

SIGNATURE: _____ Date: _____

Description of Authority to sign if personal/legal representative:

_____