North Carolina Central University
Student Health and Counseling Services
PO Box 19491
Durham, NC 27707
Phone: (919) 530-6317 Fax: (919) 530-7969

Authorization to Release and/or Disclose Protected Health Information

Please allow five business days for receipt of information when requesting records from NCCU.

Patient's Name:_____ DOB:_____

Banner ID or SSN: _____ Phone Number: _____

Address: _____City/State/Zip Code:_____

Please check one and provide the requested information:

_____ I hereby authorize NCCU Student Health and Counseling Services and its healthcare providers to disclose my Protected Health Information to the following organization and/or person.

Name:_____
Address:_____
Phone: _____ Fax:_____

_____ I hereby authorize, (health care provider or person),_____ to disclose my Protected Health Information to Student Health and Counseling Services at NCCU.

I authorize the following information to be disclosed: (Please check all that apply)

- ☐ Progress/Physician Notes
- ☐ Psychiatrist/ Counseling Notes
- ☐ Annual GYN Exam/Pap Smear
- ☐ Physical Examination
- ☐ Immunization Records
- ☐ Depo-Provera/Rx Notes
- ☐ Discharge Summary
- ☐ Pathology Report
- ☐ EKG/EMG/EEG
- ☐ Laboratory Report
- ☐ Emergency Dept. Report
- ☐ X-Rays
- ☐ Other:_____

Specify Dates of Service/Treatment (otherwise all dates included):_____

I understand that I may revoke this authorization at any time. My revocation must be in writing in a letter provided to Student Health Services at NCCU. The revocation will not apply to information that has already been released in response to this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that I may be charged to cover the costs of copying, including the cost of supplies and mailing, Protected Health Information. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date of signature.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date