Florida State University
Thagard Student Health Center
Medical Records Office
Tallahassee, Florida 32306-2140
Phone (850) 644-5523 Fax (850) 644-2737

OFFICE USE ONLY

ID CHECKED __________
PICK UP __________
MAIL __________
COMPLETED __________
PAID __________
EMPLOYEE __________

Authorization for the Use and Disclosure of Protected Health Information

Thagard Student Health Center (TSHC) cannot release your health information without your permission except in certain situations according to Federal law and Florida Statute. I understand by signing this form, I am giving TSHC permission to release the information I have indicated below. I understand that this release of information authorization is valid for 90 days after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with it. Information documented in my record after the date of my signature will not be released.

There is no charge when TSHC records are sent from TSHC to another licensed medical provider. Beyond this service, I agree to be responsible for the cost (if applicable) of copying these records, including copying fees, labor, supplies and postage. The charge will be $1.00 per page for the first 25 pages and $0.25 per page thereafter. I agree to pay for this service prior to it being rendered. Please note that it takes 7-10 business days for records to be received. A minimum of 24 hours is required to process requests except in situations of a medical emergency.

I request and authorize:	To release my medical information to:
______________________	______________________
______________________	______________________
______________________	______________________

Medical Records requested:

_________Entire Medical Record (Including HIV information, counseling and test results)
(initial)

_________ Partial Medical Record (Please specify dates of visits and/or diagnostic studies to forward) _______________
(initial)

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Mental Health Record requested:

__________Entire Mental Health (Including HIV information, counseling and test results)
(initial)

__________Partial Mental Health Record (Please specify dates of visits and/or reports) _______________
(initial)

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Name: ______________________ **Birthdate:** ______________

ID#: ______________________ **Phone:** ______________

Address: ______________________________________

Signature: ______________________ **Date:** ______________