

**AUTHORIZATION for the Use and/or Disclosure
Of HEALTH INFORMATION
(Not to be used for Psychotherapy Notes)
UNIVERSITY OF SOUTHERN MAINE
UNIVERSITY HEALTH AND COUNSELING SERVICES**

**P0 BOX 9300
Portland, Me. 04104-9300
Ph: 207-780-4211
Fax: 207-780-4911**

**110 Upton Hall
37 College Ave.
Gorham, Me. 04038
Ph: 207-780-5411
Fax: 207-780-5032**

Name: _____ **Address:** _____

Telephone: _____ **Student ID#:** _____ **DOB:** _____

Instructions: Both State and Federal Law require all of the following sections of this form to be completed. Please note incomplete or inaccurately completed forms will not be honored by University Health and Counseling Services.

I hereby authorize the use and/or disclosure of my health information by University Health and Counseling Services and any employee or member of the workforce as described below. University Health and Counseling Services will only disclose information that it has generated unless additional information is specifically requested. List the type and amount of information to be used or disclosed, and dates of services if applicable:

Entire Record **Women's Health Record including Paps** **Other List below**

ATHLETIC PHYSICALS

I understand that my specific consent is required to use and/or disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. Please fill out all of the sections even if one or more of them are not applicable to you. Any of the following sections not completed will be presumed to be a refusal to authorize use and/or disclosure of such information. (The information below will not be FAXED even if disclosure is authorized.)

A) HIV status information, I DO ___/DO NOT ___ (Check one) authorize the use and/or disclosure of health information related to testing, diagnosis or treatment of HIV, ARC or AIDS, pursuant to 5 M.R.S.A. Ch. 501.

B) Substance Abuse Treatment Information. I DO ___/DO NOT ___ (Check one) authorize use and/or disclosure of health information related to treatment, testing or diagnosis of alcohol or substance abuse pursuant to 42 U.S.C.290dd-2 and 42 CFR Part 2. Treatment information disclosed pursuant to 42 CFR Part 2 may not be re-disclosed without the Individual's express written authorization or as otherwise permitted by law.

C) Mental Health Treatment Information. I DO ___/DO NOT ___ (Check one) authorize use and/or disclosure of health information related to mental health treatment. Mental Health Treatment Information does not include "Psychotherapy Notes" under 45 CFR '164.501, which cannot be disclosed pursuant to this Authorization.

D) Sexually Transmitted Disease Information. I DO ___/DO NOT ___ (Check one) authorize use and/or disclosure of health information related to testing, diagnosis or treatment of Sexually Transmitted Diseases.

Purpose of Use and/or Disclosure: **IN FULFILLMENT OF REQUIREMENTS FOR ATHLETICS DEPARTMENT**

Release Information to (Name of Facility): **USM ATHLETIC TRAINING SERVICES**

Address: **37 College Ave. Costello Sports Complex**

City/State/ZIP: **Gorham, ME 04038**

Subsequent Disclosures: I DO ___/DO NOT ___ (Check One) authorize subsequent disclosures to be made of the health information above. This does not apply to re-disclosure of alcohol or substance abuse treatment information disclosed under 42 CFR Part 2, under section (B) above.

- * I understand I have the right to revoke this authorization at any time.
- * I understand if I revoke this authorization I must do so in writing and present my written revocation to Kristine Bertini, Director of University Health and Counseling Services.
- * I understand the revocation will not apply to information that has already been released in response to this authorization.
- * I understand that revocation may be the basis for the denial of health benefits or other insurance coverage or benefits.
- * Unless otherwise revoked, this authorization will expire in 30 months.
- * I understand that authorizing the disclosure of this health information is voluntary.
- * I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable), except (a) if my treatment is related to research, then an authorization may be required; or (b) if the purpose of the health care is solely to create protected health information to be provided to a third party, then an authorization may be required.
- * I may refuse to disclose all or some health information, but that refusal may result in improper diagnosis or treatment, denial of coverage or claim for health benefits or other insurance or other adverse consequences.
- * Partial or incomplete disclosures, as compared to the information requested to be disclosed, will be labeled as such.
- * I understand that I have a right to a copy of this authorization.
- * I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules.

If I have questions about disclosure of my health information, I may contact Kristine Bertini, Director of University Health and Counseling Services.

Signature: _____ Date: _____

IF NOT SIGNED BY THE INDIVIDUAL, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Parent/Guardian: _____ Date: _____
(If under 18 years of age)

Personal Representative: _____ Date: _____

Relationship to the Individual: _____

Describe Authority to Act for Individual: _____

RE-DISCLOSURE OF MEDICAL RECORD INFORMATION IS STRICTLY FORBIDDEN BY RECIPIENTS UNLESS DULY AUTHORIZED BY THE PATIENT.

Revised: 07/05/2006 TB

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I hereby authorize the use and/or disclosure of my health information from:

Name of Facility: USM Athletic Training Services

Address: 37 College Ave. Costello Sports Complex

City/State/Zip: Gorham, ME 04038

List the type and amount of information to be used or disclosed, and dates of service if applicable below:

Entire Record **Women's Health Record including Paps** **Other List below**

I understand that my specific consent is required to use and/or disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. Please fill out all of the sections even if one or more of them are not applicable to you. Any of the following sections not completed will be presumed to be a refusal to authorize use and/or disclosure of such information. (The information below will not be FAXED even if disclosure is authorized.)

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Subsequent Disclosures: I DO ___/DO NOT ___ (Check One) authorize subsequent disclosures to be made of the health information above. This does not apply to re-disclosure of alcohol or substance abuse treatment information disclosed under 42 CFR Part 2, under section (B) above.

Purpose of Use and/or Disclosure: _____

Release Information to:

<p>University of Southern Maine Student Health Services 37 College Avenue 110 Upton Hall Gorham, ME 04038 Phone 780-5411 Fax 780-5032</p>
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- * I understand that I have a right to a copy of this authorization.
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