PURDUE UNIVERSITY
AUTHORIZATION FOR USE, DISCLOSURE OR RELEASE OF
PROTECTED HEALTH INFORMATION AND MEDICAL RECORDS

I hereby request and authorize the use, disclosure and/or release by Purdue University M.D. Steer Audiology and Speech, Language Clinics and its employees, of medical records, including my social security number, or other protected health information as described below:

Patient's Name: _____ Date of Birth: _____

Patient's Address_____
(street) (city) (state) (zip)

Patient's I.D.#: _____ Phone #: _____

Please identify who is to receive the medical records or other medical information **(name and address or name and fax #):**

_____

_____

Please describe specifically what medical records or other health information may be used or released:

AUDIOLOGY TEST RESULTS & REPORT

If this request is not made by the Patient, what is the reason for this request?
BY PATIENT OR PARENT REQUEST

Unless the "No" box is marked, this Authorization extends to such psychiatric, mental health, and drug and alcohol abuse treatment information, if any, as may be contained in said medical record including information protected by I.C. 16-39-1-9, I.C. 16-39-2-1 through 16-39-4-2 and I.C. 16-41-8-1. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol or drug abuse. ☐ No

Unless the "No" box is marked, the Authorization also extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record. ☐ No

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that Purdue University will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to SLHS Dept., 715 Clinic Drive, West Lafayette, Indiana, 47907. The revocation will be effective upon receipt by the University, except to the extent that the University has taken action in reliance on this authorization. I further understand that, this authorization will expire as follows: (1) sixty (60) days from the Signature Date for all records except mental health records, and (2) one hundred eighty (180) days from the Signature Date for mental health records, unless I specify a different expiration date or event here:

- ■ **As long as disclosure to provider(s) named above who will receive my medical records, is necessary.**
- ☐ **As long as use or disclosure indicated above is needed for educational purposes.**
- ☐ **As long as use or disclosure indicated above is needed for promotional purposes.**

After the expiration date, this authorization will no longer be effective, and no further information will be furnished pursuant to it.

I understand that there may be a charge to cover actual costs incurred by Purdue University in preparing and delivering the information requested in this authorization, in accordance with Indiana statutes and Purdue policies.

Signed: _____ Relationship to Patient: _____
Patient or Legal Representative

_____ Date: _____
Printed name if not Patient

Witness: _____ Date: _____

☐ Patient was offered a copy of this form and declined.

Revised 2/2020