Methodist University Health Center
5400 Ramsey Street
Fayetteville, NC 28311
MUHC@methodist.edu
(910) 630-7164
(910) 630-7544 fax

Name: ______________________
MU Id #: ______________________
Date of Birth: ___________________

AUTHORIZATION TO OBTAIN, RELEASE OR USE HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

Check One:

☐ Release Records to
☐ Obtain Records from

Name/Organization: ____
Address: ____
City: ____________________ State: __________ Zip code: __________
Phone: ____________________ Fax ______________

Purpose for Disclosure: ☐ Continuity of Care between Health Care Providers ☐ Disability Determination ☐Coach/AT Department ☐ Insurance Claim ☐ Academic Support and Accommodation ☐ Employment ☐Parent/Guardian ☐ Other______________________

☐ Please mail the copies to the address listed above
☐ Please fax the copies to the fax number listed above (limited to healthcare facilities)
☐ Please send records via Health Center send files to the e-mail address listed: ______________________________

A SEPARATE AUTHORIZATION IS REQUIRED TO OBTAIN RECORDS MAINTAINED BY THE METHODIST UNIVERSITYHEALTH CENTER.
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.
I do NOT authorize MUHC to disclose any of the following information:

☐ AIDS/HIV ☐ Alcohol/Drug Abuse
☐ Sexually Transmitted Diseases ☐ Behavioral/Mental Health

Requested Records		**Released Records**	
☐Entire Record	☐Immunization Record	☐Entire Record	☐Immunization Record
☐Visit Notes	List dates:	☐Visit Notes	List dates:
☐Radiology reports	List dates:	☐Radiology Reports	List dates:
☐Lab Reports	List dates:	☐Lab Reports	List dates:
☐Allergy Records	List dates:	☐Allergy Records	List dates:
☐Other	Specify:	☐Other	Specify:

By signing below, I acknowledge that I have read and understand this Authorization. I have voluntarily given my authorization to the Health Center to disclose my records to or obtain them from the person/organization listed above, and that I may revoke this Authorization, at any time by providing a written notice to the Health Center to the attention of the Manager, Registration and Health Information (MUHC@methodist.edu). The revocation shall be effective except to the extent that the Health Center has already used or disclosed information in reliance on the Authorization. For more detailed information on how to revoke this authorization, please refer to ***Notice of Health Information Privacy Practices***, available at https://www.methodist.edu/health-services.

I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this Authorization. Unless otherwise revoked, this Authorization will expire one year from the date signed or on the following date, event or condition:______________________.

Signature______________________________________ Date ______________
(Patient)

Signature______________________________________ Date______________
(Personal Representative/Legal Guardian – if patient is 17yrs old or younger)

June 2021