Bucknell University Student Health Service

Ziegler Health Center **Phone: 570-577-1401**
Lewisburg, PA 17837 **Fax: 570-577-3570**

Authorization for Disclosure of Protected Health Information

_____ _____
Patient Name Date of birth Last year attended BU

_____
Address

_____
Phone Number Email BU ID#/SS #

I hereby authorize the disclosure of the following information for the purpose of: _____

____ Immunization Information **____ Most recent Gyn Exam and PAP result**

____ Lab tests dated _____ **____ X-Ray results dated _____**

Other - Please Specify:

_____

To: _____ **From: _____**
Name of individual or agency **Name of individual or agency**

_____ _____
Address **Address**

_____ _____
Phone/Fax **Phone/Fax**

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the Privacy Officer, Bucknell University Student Health Service, Ziegler Health Center, Lewisburg, PA 17837. Unless otherwise revoked, this authorization will expire on the following date or 6 months from the date of the request if no date is specified: **Expiration date: _____**

Potential for Re-disclosure
If the persons or entities that are authorized to receive this information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws will no longer protect the disclosed health information.

Rights of the individual

- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization. If you refuse to sign this authorization, Bucknell University Student Health Service will not deny you any treatment, except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party (i.e. a pre-employment physical or research related care).

_____ _____
Patient Signature **Date**