Appalachian State University, MS Shook Student Health Service
ASU Box 32070 Boone, NC 28608 (828)262-3100 FAX (828)262-6958
Attention: Medical Records & Immunization

AUTHORIZATION FORM

I authorize: ☐ ASU Student Health Service ***To use or disclose to (send information to):*** ☐ Patient: ☐Pick-up ☐Fax:_____ ☐ Mail to: _____ _____ _____	***I authorize:*** ☐ _____ _____ _____ Fax:_____ Phone:_____ ***To use or disclose to (send information to):*** ☐ ASU Student Health Service

The protected health information of:

Patient Name:_____ ASU Banner ID:_____

Telephone #:_____ Date of Birth:____/____/____ Date Requested:_____

Treatment Dates:_____

Information to be disclosed (please check below to indicate information requested):

	Medical History		Immunization Records		Laboratory Report
	X-Ray Files/Report		Letter/Medical Statement		Entire Medical Record
	Mental Health Records*		SDAP (Scholars with Diverse Abilities Program) Authorization		
	Other (please specify)				

*Mental Health Records can only be released to healthcare provider

I understand that my medical records are confidential and cannot be disclosed without my written consent unless otherwise authorized or required by law.

I understand the confidentiality of my medical records cannot be guaranteed by the Mary S. Shook Student Health Service if the records are disclosed by facsimile (FAX).

I agree to indemnify and save harmless Appalachian State University and its trustees, agents, and employees from all liabilities, losses, costs, damages, claims or causes of action on any kind or nature whatsoever, and expenses, including attorneys' fees, arising or claimed to have arisen out of any injuries or damages received or sustained by any person(s) or property, as a result of intentional acts or omissions of Appalachian State University or its trustees, agents, or employees, or of negligence on the part of Appalachian State University trustees, agents, or employees, in the execution, performance, or enforcement of this agreement.

This authorization form will remain in effect for 60 days and may be revoked at any time.

I have read and understand the information in this Authorization Form.

Signature of Patient or Parent/Guardian:	
Witness:	Date:

Office Use Only
☐*Mailed* ☐*Faxed* ☐*Patient Pick-Up* ☐*Scanned into EMR by*_____ *Date*_____