UNIVERSITY OF NORTH CAROLINA
SCHOOL OF THE ARTS

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth _____

Previous Name: _____

I request and authorize the University of North Carolina School of the Arts Wellness Center to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State _____ Zip Code _____

This request and authorization applies to:
□ Healthcare information relating to the following treatment condition or dates: _____

_____

_____

□ All healthcare information

□ Other: _____

Common sexually transmitted infections (STI) include herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma, venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release of my STI results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure to the test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, mental health treatment to the person(s) listed above.

Patient Signature _____ Date Signed _____

THIS AUTHORIZATION EXPIRES AT THE END OF THE SCHOOL YEAR AFTER IT IS SIGNED

Student Health Services
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