THE UNIVERSITY OF KANSAS MEDICAL CENTER
Student Health Services
Authorization for Release of Confidential Information

I, _____, born on _____, hereby authorize:

Name: _____ Phone: _____ Fax: _____

To request the following Protected Health information (PHI) to be released from my medical record/student record (check all that apply):

- ❑Immunization Information
- ❑Pap/Annual Results
- ❑Lab Work (specific dates if applicable) _____
- ❑All records
- ❑Other: _____

I request my PHI to be released to:
Name: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

Purpose for requesting information:

- ❑ Continuing Care
- ❑ Personal
- ❑ Insurance/Disability
- ❑ Legal
- ❑ Other: _____

How are we to send the requested information:
(Paper will be mailed unless otherwise specified)
□Paper □Fax (to health care provider only)
□Secure Email □CD(electronic format)
□Pick-Up at Student Health

By signing this authorization form, I understand that:

- Certain records are protected by Federal and / or State laws which prohibit the release of such records. Student Health Services will comply with such laws.
- Requests for copies of medical records and/or non-documented material may be subject to copying fees. The estimated charge for copying such records, if any will be provided in advance upon request.
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and or treatment of alcohol/drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to Student Health Services. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire upon expiration of services from student health.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Student Signature of Witness

_____
Printed Name of Student

Send completed form to:
Student Health Services
3901 Rainbow Blvd., Kansas City, Kansas 66160-7370
Phone (913) 588-1941 Fax (913) 588-1943
Attach Signed Authorization to E-mail: studenthealthrecords@kumc.edu

Place scanned copy into patient's medical/student record and provide a signed copy to the patient.