LAFENE HEALTH CENTER **Telephone :(785) 532-6544**
Kansas State University, 1105 Sunset Avenue, Manhattan KS 66502-3575 **FAX: (785) 532-3425**

AUTHORIZATION FORM

FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All sections 1- 7 must be completed. Please print all information except for signatures.

Section 1: PATIENT IDENTIFICATION.

Print Name: ______________________________ Alias/Maiden: ______________

Street Address, City, State & Zip Code ______________________________

Student I.D. Number: ______________________ Date of Birth: ______________________

Section 2: TYPES OF RECORDS/INFORMATION TO BE DISCLOSED. ***Initial*** all appropriate boxes.

☐ 1. All records contained in my medical chart to include all records from outside providers. (This will include ***everything*** transferred to us.) **Excluding** the three types of records listed in number 3 of this section.

☐ 2. Partial medical records. Please specify specifically which records you want disclosed. ______________________

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3. To disclose the following protected information, authorization is designated by initialing the appropriate box.

Alcohol or substance abuse or treatment.		Psychiatric/mental health diagnosis or treatment by a mental health provider excluding psychotherapy notes.	
HIV antibody test results/AIDS Diagnosis			

Section 3: Facility authorized to SEND information.

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PH: ______________ FAX: ______________

Section 4: Facility/Person authorized to RECEIVE information.

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PH: ______________ FAX: ______________

Section 5: EXPIRATION OF AUTHORIZATION

This AUTHORIZATION will expire on ______________________ (date). Not to exceed one year or if left blank, this AUTHORIZATION will expire 90 days from date of signature in section 7.

Section 6: PURPOSE for which you want records disclosed. ______________________________

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Section 7: AUTHORIZING SIGNATURE

- I understand this information may be transmitted by fax if necessary for **urgent** medical care.
- I understand that if the person or entity that receives the described records/information is not a healthcare provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and may no longer be protected by those regulations.
- I understand that federal or state law may protect certain records and I am requesting that any and all such protected records be disclosed under this authorization if initialed in Section 2, #3.
- I understand that I may revoke this authorization at any time by delivering a *written* revocation to: Health Information Management Department, Lafene Health Center, 1105 Sunset Ave., Manhattan, KS 66502
- If I revoke this authorization it will have *no* effect on actions already taken on reliance on this form.
- The covered entity will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

____ ______________________

(Signature of patient) or if under 18 years of age (Parent, Legal Guardian, Legal Representative) (Date)

If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1. ______________________

____ ______________________

(Witness Signature) (Date)

FOR OFFICIAL USE: DISCLOSED BY: ______________________ DATE: ______________