KU WATKINS HEALTH SERVICES
The University of Kansas

Watkins Memorial Health Center
1200 Schwegler Dr. • Lawrence, KS 66045
www.studenthealth.ku.edu

Student Clinic: (785) 864-9500
Faculty & Staff Clinic: (785) 864-9565
WHS Pharmacy: (785) 864-9512

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION

I authorize my health information to be released:

From:	**To:**
Name/Agency:_____	Name/Agency:_____
Address:_____	Address:_____
_____	_____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

Date or event on which I want this authorization to expire: _____
(If no expiration date is specified, this authorization will expire one year from date signed.)

Purpose of Use/Disclosure:
☐ Continuation of Care ☐ Other: _____

Information to be disclosed will be for past 3 years only OR for this date range: _____**to** _____
☐ ALL – This includes encounter notes, phone notes, lab and x-ray results, HIV tests, medical history, immunizations, medications, mental health/ADD/ADHD records, substance abuse records, etc.
☐ Complete immunization record only
☐ Lab work and/or x-ray results
☐ Pre-employment physical, including testing performed
☐ TB assessment results
☐ Fitness for duty or work
☐ Records from outside sources
☐ Other: (describe) _____

PLEASE DO NOT INCLUDE: _____

Please provide the requested information <u>in this format</u>: (Note: To be completed only if WHS is releasing records)
☐ In paper format only or ☐ Electronically stored on a CD (only when provided by WHS; in PDF format)

Please provide my information <u>in this fashion</u>: (Note: To be completed only if WHS is releasing records)
☐ I will pick-up my information in person. (Proof of identification must be provided at pick-up.)
☐ I will have _____pick-up my information on my behalf: (Proof of identification must be provided at pick-up.)
☐ U.S. Postal Service; Address: _____
(Note: If expedited delivery is required, the patient will be charged for all related costs.)
☐ Fax number: _____
☐ Electronically – Sent to my WHS patient portal
☐ Electronically – Sent to email address: _____ (WHS does not encourage use of email because it is not a secure medium for this purpose.)

*I understand that once the uses/disclosures have been made as permitted by this form, the information may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization but that this will not affect my ability to obtain treatment. I understand that WHS may only disclose my past medical information and that this form does NOT authorize disclosure of any information related to <u>future</u> care I may receive. I understand that I may revoke this authorization at any time by delivering in writing a revocation to WHS, but if I do, it will not have any effect on **previous** disclosures WHS made based upon this authorization. I understand I am entitled to review any information to be disclosed and to have a copy of same (at my expense).*

_____	_____	_____
Patient's Signature	Printed Name of Patient	Date
_____	_____	_____
Phone Number of Patient or Personal Representative	Patient's Date of Birth	KU ID#
_____	_____	_____
Personal Representative's Signature	Printed Name of Personal Representative	Date

_____
Personal Representative's Authority to act for Patient (e.g. Parent, Guardian, etc.)

Please allow 10 (ten) business days for processing. Charges do apply unless records sent to a health care provider.

Prepayment of Charges for Duplication of Records Is Required

Processed by: _____(Include initials) ☐ *ROI sent* ☐ *Documents sent Any Charges:* ☐ *N/A* ☐ *$_____ Date: _____*

Copy of authorization must be given to patient if patient did not initiate the request.