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: _____

Please specify the date or event upon which this authorization expires: _____

NOTE: 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
☐ TB Assessment results
☐ Lab work and/or x-ray results
☐ Fitness for duty or work
☐ Pre-Employment Physical, which may include any testing performed
☐ Records from outside sources
☐ Other: (describe) _____

PLEASE DO NOT INCLUDE: _____

*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 future 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

_____
Description of 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.

Place Patient Label Here

Prepayment of Charges for Duplication of Records Is Required

Reviewed by: _____
*Charges:*_____ *Date sent:* _____

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