University of Kansas
Watkins Health Services
1200 Schwegler Drive Lawrence, KS 66045
studenthealth.ku.edu

Student Clinic: (785) 864-9500
Faculty & Staff Clinic: (785) 864-9565
Fax: (785) 812-0213
Email: whs-notifications@ku.edu

Authorization for Use/Disclosure

I authorize my health records to be released:

From (where records are now:)
Name/Agency:_____
Address:_____
Phone:_____ Fax:_____

To (where records are to go:)
Name/Agency:_____
Address:_____
Phone:_____ Fax:_____

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, lab and x-ray results, HIV tests, immunizations, mental health/ADD/ADHD records, substance abuse records, etc.
□ Complete immunization records only
□ TB Assessment Results
□ Lab Work and/or x-ray results
□ Fitness for duty or work
□ Pre-employment physical, including tests performed
□ Records from outside sources
□ Other (describe):_____

Please do not include:_____

Please provide information in this fashion: (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 (Note: If expedited delivery is required, the patient will be charged all related costs.)
□ Fax Number
□ 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 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.

Patient's Signature. Must be handwritten original signature:_____
Printed Name of Patient:_____
Date:_____ Phone Number of Patient or Personal Representative:_____
Patient's Date of Birth:_____ University of Kansas ID Number:_____
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 not apply unless records sent to health care provider or patient.

Information below is for office use only

_____

□ ROI request sent:_____ (Initials & Date)
□ Documents sent:_____ (Initials & Date)
Any Charges
□ N/A
□ $:_____

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