Authorization for Use and Disclosure of Protected Health Information

Drury University Student Health Center, FSC 107, 900 N. Benton, Springfield, MO 65802
417/873-7218……..Fax 417/873-7533

Patient Identification

Name:_____Date of Birth:_____
Address:_____
_____
Social Security #_____Phone #_____

Information to Be Released—Covering the Periods of Health Care while attending Drury University

From:_____(date) To:_____(date)
From:_____(date) To:_____(date)

Purpose of Request

__Treatment or consultation
__At the request of the patient
__Billing or claims payment
__Other:_____

Please check type of information to be released:

__Immunization Records	__History & Physical	__X-ray reports	__X-ray films/images
__Complete health record	__Discharge summary	__Photographs, videotapes	__EKG
__Nurses Notes	__Operative Report	__Lab Results	__EEG
__ Pertinent Documentation	__Consultation reports	__Progress notes	__Itemized bill

__Other (specify)_____

I, the undersigned, authorize and request Drury University Student Health Center to:
___**Release** information to the following person/institution
___**Request** information from the following person/institution

Name: _____

Address: _____

_____

Fax Number: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological, and/or HIV/AIDS Records Release

I understand that my medical record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or Treatment, and/or other sensitive information. I agree to release of any or all of the above named information.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Drury University Dean of Student's Office. Unless revoked, this authorization will expire on the following date or event_____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand that once information is released, it may be redisclosed by the recipient and no longer protected by the federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatment(s) or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Drury University Student Health Center/Cox Health to use and disclose the protected health information specified above.**

SIGNATURE:_____Date:_____
(Patient, parent if minor child, or guardian)
Relationship to Patient:_____

Identity of Requester Verified via:
___Photo ID ___Matching Signature ___Other, specify_____
Verified by:_____

This form will become a part of the student's health records.