THE UNIVERSITY OF KANSAS MEDICAL CENTER
Student Health Services
Authorization for Release of Confidential Information

I, ____________________________________, born on ___________________________, hereby authorize:

Name: ____________________________ Phone: _______________________ Fax: _______________

To request the following health information to be released from my medical record/student record (check all that apply):

- ❑Immunization Information
- ❑Pap/Annual Results
- ❑Lab Work (specific dates if applicable) _________________________
- ❑All records
- ❑Other: ____

I request my health information to be released to:
Name: KU Medical Center – Student Health Center

Address: 1012 Student Center, Mail Stop 4044, 3901 Rainbow Blvd.

City/State/Zip Code: Kansas City, KS 66160

Phone: 913-588-1941 Fax: 913-588-1943

Purpose for requesting information:

- ❑ Continuing Care
- ❑ Personal
- ❑ Insurance/Disability
- ❑ Legal
- ❑ Other: ___________________

How are we to send the requested information:
(Paper will be mailed unless otherwise specified)

□Paper □Fax (to health care provider only)
□Secure Email □CD(electronic format)
□Pick-Up at Student Health

By signing this authorization form, I understand that:

- Certain records are protected by Federal and / or State laws which prohibit the release of such records. Student Health Services will comply with such laws.
- Requests for copies of medical records and/or non-documented material may be subject to copying fees. The estimated charge for copying such records if any will be provided in advance upon request.
- Health information may include records relating to mental health care, communicable diseases, HIV/AIDS, and or treatment of alcohol/drug abuse. I authorize the release of these records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to Student Health Services. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: ___________________________________. If I fail to specify an expiration date/event/condition, this authorization will expire in one year.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

____
Signature of Patient

____
Signature of Witness

____
Printed Name of Patient

____
Date