

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:

<input type="checkbox"/> Immunization Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films/images
<input type="checkbox"/> Complete health record	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Photographs, videotapes	<input type="checkbox"/> EKG
<input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Lab Results	<input type="checkbox"/> EEG
<input type="checkbox"/> Pertinent Documentation	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes	<input type="checkbox"/> Itemized bill
<input type="checkbox"/> 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 re-disclosed 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.