AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

My health record is private and is known under the law as "Protected Health Information (PHI)." By completing and signing this form, I, or my legal representative, agree to allow the Provider set forth below to share my PHI with the people or entities listed below for the purposes listed below.

SECTION A. INDIVIDUAL INFORMATION		
INDIVIDUAL'S NAME (LAST, FIRST, MIDDLE INITIAL):	DATE OF BIRTH (MM/DD/YYYY):	
STREET ADDRESS (INCLUDING CITY, STATE, AND ZIP):		
PHONE NUMBER:		

SECTION B. RECIPIENT AUTHORIZATION

I AUTHORIZE THE FOLLOWING TO RELEASE, DISCLOSE, AND DISCUSS THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION AS INDICATED HEREIN:

PERSON/ORGANIZATION NAME: Wichita State University, Counseling and Prevention Services	
ADDRESS (INCLUDING CITY, STATE, AND ZIP): 1845 Fairmount Street, Wichita, KS, 67260-0092	
PHONE: (316) 978-4792	FAX: (316) 978-3517

WHO CAN RECEIVE AND USE THE PROTECTED HEALTH INFORMATION ("REQUESTOR")?

PERSON/ORGANIZATION NAME:	
ADDRESS (INCLUDING CITY, STATE, AND ZIP):	
PHONE:	FAX:

PERSON/ORGANIZATION NAME:	
ADDRESS (INCLUDING CITY, STATE, AND ZIP):	
PHONE:	FAX:

WHAT INFORMATION CAN BE DISCLOSED? COMPLETE THE FOLLOWING BY INDICATING THOSE ITEMS THAT YOU WANT DISCLOSED. PLEASE NOTE: DUE TO THE SENSITIVE NATURE OF SOME PHI, YOUR SPECIFIC AUTHORIZATION IS REQUIRED PRIOR TO DISCLOSURE.

Please check all that apply:

- ☐ Full Record
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge/TX Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Diagnosis only
- ☐ Radiology Reports & Images
- ☐ Video/Audio/Picture
- ☐ Lab Results
- ☐ Consultation/Diagnostic Reports
- ☐ Dates of Service
- ☐ Other (please specify) _____

Sections below will need initials: _____

_____ Mental Health Records (e.g., psychological testing reports, medical/pyschiatric reports, treatment plan and summary
_____ Psychotherapy Notes and Evaluations
_____ Drug, Alcohol or Substance Abuse Records
_____ Genetic Information (including genetic test results)
_____ HIV/AIDS Test Results/Treatment

SECTION C. PURPOSE OF THE REQUEST

The purpose of the request is:

- ☐ At the request of the patient/patient representative
- ☐ Sanction Compliance
- ☐ Coordination of Treatment
- ☐ Other(specify) _____

SECTION D. SCOPE OF THE REQUEST

☐ Provider may **discuss orally** my PHI with the Requestor ☐ Requestor may **inspect and/or obtain copies** of my PHI

SECTION E. EXPIRATION

This authorization will expire:

☐ 1 year from the date of my signature
☐ 3 years from the date of my signature
☐ 5 years from the date of my signature
☐ On the following date (insert date): _____
☐ On the following event (please specify): _____
☐ 180 days after I am no longer enrolled at WSU

SECTION F. SIGNATURE/DATE

By signing below, I understand that:

- I do not have to sign this authorization
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law
- Other types of information shared under this authorization, including but not limited to mental health treatment information, may be re-disclosed by the person or organization I identified above, and such disclosures may be made to anyone, including but not limited to media outlets and the general public, and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the Provider that maintains your records and include a copy of this form if you have a copy of it.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this authorization.
- Any facsimile or copy of this authorization authorizes the release of the records requested herein.
- I acknowledge that I have received a copy of this authorization.

Signature of Individual (if 18 years of age or older)**:** _____ Date _____

Signature of Parent or Legal Representative (if applicable)**:** _____ Date _____

Relationship to Individual, if not signed by Individual: _____