1845 Fairmount
209 Ahlberg Hall
Wichita, KS 67260-0092
(316) 978-3620 Fax: (316) 978-3517

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: ____
Last First Middle Name

Date of Birth: ________________________**myWSU ID#** ________________________

I hereby authorize:

____
Name Telephone Number

____
Address Fax Number

to release the protected health information indicated below to:

____
Name Telephone Number

____
Address Fax Number

Requested Information
[NOTE: You will be charged__.10__ per one-sided page for paper records plus a $5.00 staff time charge. If you request your records be faxed, there is a $5.00 fax charge. You understand that forwarding information by telefacsimile ("fax") transmission is not a secure form of disclosure. By signing this authorization, you acknowledge this uncertainty and confirm the fax number you are providing is in fact the correct one for the designated recipient.]

☐ Billing Records ☐ Lab Reports ☐ Pathology Reports ☐ Radiology Reports
☐ Physician/Nurse Notes ☐ Other: Please Specify:________________________
☐ Psychological Records which may contain information on intake/ assessment/counseling/treatment/ diagnosis (this may include records marked as "Sensitive").
☐ Information created or received from other providers (Specify which information, provider(s) or "all").

____
☐ Entire designated record set

Purpose of the Requested Use or Disclosure

The purpose of the use or disclosure is: ☐ at the request for the patient or ☐ other

____
[Indicate specific reason.]

(over)

Important Information:

The information authorized for release may include records which indicate: the presence of a communicable or venereal disease including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Chlamydia, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and/or Psychological Records which may contain information on intake/ assessment/counseling/ treatment/diagnosis (this may include records marked as "Sensitive".)

Please allow a minimum of 48 to 72 hours for records request to be processed by Student Health Services.

Student Health Services will accept a telefacsimile ("fax") transmission of this authorization provided it is accompanied by a copy of photo identification of the patient or legal representative* OR the authorization has been signed in front of a notary public.

By signing below, I certify that I understand that:

1. Unless I revoke this authorization earlier, it will expire one year from the date of my signature.
2. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment.
3. If the persons or entities authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
4. Once I sign this authorization, Student Health Services can rely on it until I revoke it or, if I have not revoked it, until it expires. I can revoke this authorization by delivering a dated and signed letter to our clinic at 1845 Fairmount, 209 Ahlberg Hall, Wichita, Kansas 67260-0092.

Signature: ______________________________________ Date: ______________________________
(Patient or Legal Representative)

Telephone number:____

Capacity of Legal Representative (if applicable)*: _____________________________________

*May be requested to provide verification of representative status.

Wichita State University Privacy Officer:
David Moses
General Counsel, Privacy and Compliance Officer
Wichita State University
1845 Fairmount
Wichita, KS 67260-0205
316-978-6791

HIPAA Document
Retain for six (6) years

Office Use Only: Payment Due:_____________________Photo ID Checked:____________

Date Records Sent:_________________Processed by:_________________