Pittsburg State University
Student Health Services
Consent for Release of Information

UNDER HIPAA REGULATIONS, THIS RELEASE IS ONLY VALID IF ALL BLANKS ARE FILLED IN.

Patient's Name: _____

Address: _____ _____ _____ _____

Birth Date: _____ **Telephone Number:** _____

PSU ID #: _____

I HEREBY AUTHORIZE PSU STUDENT HEALTH SERVICES TO ☐ **Release To** ☐ **Obtain From :**

Name of Individual or Agency: _____

Address: _____ _____ _____ _____

Telephone Number: _____ **Fax Number:** _____

THE FOLLOWING INFORMATION IS REQUESTED:

Dates of Service: From: _____ **To:** _____

☐ Emergency Room Record(s)	☐ Cardiac Studies	☐ Nursing Notes	☐ Entire Record
☐ History & Physical	☐ Lab Report(s)	☐ Discharge Summary	☐ Other (indicate below)
☐ Progress Notes	☐ Physicians' Orders	☐ Pathology Report(s)	_____
☐ Consult Report(s)	☐ Rehab Services	☐ Women's Health	_____
☐ Operative Report(s)	☐ Medication Record	☐ Imaging/Radiology Report(s)	_____

I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse (CFR 42)

THE REQUESTED INFORMATION WILL BE USED FOR (CHECK ONE OR MORE BELOW):

☐ Coordination of Services/Treatment Facilitation ☐ Own Records ☐ Attorney

☐ Insurance ☐ Other: _____

I understand that once the uses/disclosures have been made as permitted by this form, the records/information may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by delivering in writing a revocation to Pittsburg State University, University Counseling Services, but if I do, it will not have any effect on actions the Clinic took in reliance on this authorization prior to receiving the revocation. I authorize the use/disclosure of the records/information described above.

Specify the date or condition upon which this consent expires: _____
(not to exceed one year)

_____ _____ _____
Patient signature or parent, guardian or authorized representative | Relationship to Patient | Date

_____ _____
Witness | Date

****PREPAYMENT OF CHARGES FOR DUPLICATION OF RECORDS IS REQUIRED****
Please allow ten business days for processing

Charges: $ _____ Date Sent: _____
Reviewed by: _____
No charges if records sent to a health care provider

Records Requested by: _____

Pittsburg State University – Student Health Services
1701 S Broadway, Pittsburg, KS 66762
PHONE NUMBER: 620-235-4452 FAX NUMBER: 620-235-6135 (Nurses' Station) or 620-235-4455 (Medical Records)