LAFENE HEALTH CENTER
Kansas State University, 1105 Sunset Avenue, Manhattan KS 66502

Telephone: (785) 532-6544
FAX: (785) 532-3425

RECORDS RELEASE FORM

FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Instructions: All sections 1- 7 must be completed. Please print all information except for signatures.

Section 1: PATIENT IDENTIFICATION.

Print Name:_____Alias/Maiden:_____

Street Address, City, State & Zip Code_____

Student I.D. Number:_____ Date of Birth_____

Section 2: TYPES OF RECORDS/INFORMATION TO BE DISCLOSED. ***Initial*** all appropriate boxes.

☐ 1. All records contained in my medical chart to include all records from outside providers. (This will include ***everything*** transferred to us.) **Including** the three types of records listed in number 4 of this section.

☐ 2. Partial medical records. Please specify specifically which records you want disclosed. _____
_____

☐ 3. Communication between _____ and healthcare provider for ____ all visits (or) _____dates only.
(parent, office of student life, other)

4. To **NOT** disclose the following protected information, initial the appropriate box.

Alcohol or substance abuse or treatment		Psychiatric/mental health diagnosis or treatment by a mental health provider *excluding psychotherapy notes*	
HIV antibody test results / AIDS Diagnosis			

Section 3: PURPOSE for which you want records disclosed. _____
_____

Section 4: Facility/Person authorized to SEND information.

_____
_____
_____
_____

PH:_____FAX:_____

Section 5: Facility/Person authorized to RECEIVE information.

_____
_____
_____
_____

PH:_____FAX:_____

STUDENT RECORDS (FERPA)

Section 6a: EXPIRATION OF AUTHORIZATION
This AUTHORIZATION **does not expire** unless an expiration date is listed below:

_____ (date)

- I understand this information may be transmitted by fax if necessary for **urgent** medical care.
- I understand that if the person or entity that receives the described records/information is not an educational institution, the records/information may **NOT** be redisclosed and may no longer be protected by those regulations.
- I understand that federal or state law may protect certain records and I am requesting that any and all such protected records be disclosed under this authorization if initialed in Section 2, #4.
- I consent to the release of the above records.

The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. 1232g, prohibits access to the enclosed records by anyone other than the recipient unless specific written permission for further dissemination is received from any and all students or former students of this institution who are personally identifiable from information contained in the records.

NON-STUDENT RECORDS (HIPAA)

Section 6b: EXPIRATION OF AUTHORIZATION This authorization will expire on _____(date). *Not to exceed one year or if left blank, this AUTHORIZATION will expire 90 days from date of signature.*

- I understand this information may be transmitted by fax if necessary for **urgent** medical care.
- I understand that if the person or entity that receives the described records/information is not a healthcare provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and may no longer be protected by those regulations.
- I understand that federal or state law may protect certain records and I am requesting that any and all such protected records be disclosed under this authorization if initialed in Section 2, #4.
- I understand that I may revoke this authorization at any time by delivering a *written* revocation to: Health Information Management Department, Lafene Health Center, 1105 Sunset Ave., Manhattan, KS 66502
- If I revoke this authorization it will have *no* effect on actions already taken on reliance on this form.
- The covered entity will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization.
- I authorize the disclosure of the records/information described. I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy of this authorization.

_____ _____
(Signature of patient) or if under 18 years of age (Parent, Legal Guardian, Legal Representative) (Date)
If you are not the person listed in Section 1, you must describe your relationship to the person in Section 1. _____

_____ _____
(Witness signature) (Date)

FOR OFFICIAL USE: DISCLOSED BY:_____ Date:_____