Fort Hays State University
Student Health Center
600 Park Street
Hays, KS 67601
785-628-4293 – phone
785-628-4089 – fax

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

To be completed by the patient to authorize disclosure to self or others

Patient Name

Date of Birth

Current Address and Phone Number

I authorize the use or disclosure of the above named individual's health information as described below:

The following individual or organization is authorized to make the disclosure:

Address

The type of amount of information to be used or disclosed is as follows: (include dates where appropriate)

___Lab Results
___Entire Record
___X-Ray Report
___Medication List
___Current Physical
___Other
___List of Allergies
___Immunization Records

I understand that the 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 behavior or mental health services, and treatment for alcohol or drug abuse.

This information maybe disclosed to and used by the following individual organization:

Address

For the purpose of_____

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient of Legal Representative

Date