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):	myWSU ID:
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 Student Health Services	
ADDRESS (INCLUDING CITY, STATE, AND ZIP): 1845 Fairmount, Wichita KS 67260-00092	
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:

- ☐ All health information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Video/Pictures/Audio
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other (please specify) _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)

_____ Genetic Information (including genetic test results)

_____ Drug, Alcohol or Substance Abuse Records

_____ 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
- ☐ Other (please 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): _____

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.
- 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: _____

Standard Release of Records Process

Please follow the instructions to ensure the Authorization to Disclose Protected Health Information Form (Records Release) is filled out correctly.

***Please note that it might be helpful to pre-fill the first table under Section B with the name of the WSU clinic, lab, or person, and corresponding address/phone number, prior to giving to the patient to fill out.*

SECTION A: INDIVIDUAL INFORMATION

- In Section A, ensure that full name, date of birth, address, and phone number have been filled out.

SECTION B: RECIPIENT AUTHORIZATION

- In Section B, under "Who can receive and use the protected health information (Requestor)" ensure the patient has filled out the name of the person or organization, address, phone, and fax number. If there is more than one place that the patient wants the *same* information sent to, then use the last table in that section for that information. If *different information* needs to be sent to more than one person, then a separate release will need to be filled out for each person/organization.
- Ensure that the patient has selected what information they want released. If they have information that is not represented in the list, please have the patient check "other" and write what it is in the blank.
- Confirm the information that requires an initial to be released, has the patient's initials by it.

SECTION C: PURPOSE OF THE REQUEST

- Guarantee that the purpose of the request has been identified. If you do not see a selection that matches your purpose, please check other and write the purpose in there.

SECTION D: SCOPE OF THE REQUEST

- Ensure that the patient has marked the intended way you would like to release the information.

SECTION E: EXPIRATION

- Confirm that the patient has marked the date that the request will expire. Please make sure they do not exceed a maximum of 10 years.

SECTION F: SIGNATURE/DATE

- Make certain the patient has signed (if 18 or older). If the patient is a minor, make sure the parent or legal representative has signed and provided their relationship to the patient. If a patient over the age of 18 has an alternative person sign because of their inability or capacity to (e.g., guardianship or power of attorney for healthcare purposes), that paperwork will need to be filed in the electronic medical record *after* being vetted by WSU legal and *before* the information is released.

OTHER IMPORTANT INFORMATION:

- Reciprocal use of this release (e.g., another entity's name is filled out in the top box under Section B) is *not allowable* by the University.
- If a patient requests that WSU release their records to a 3rd party in another written format and you cannot get in contact with them, please contact the HIPAA privacy officer at 978-4HIP (4447) to discuss alternative options.
- Please remember that once a request to release records is made by a patient in writing, we have an obligation to release them within 15 business days.