AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A: Patient's Information, please print: Wildcat ID: _____ Phone: _____

Last name, First Name (include maiden name if applicable): _____ Date of Birth: _____

Section B: I **authorize** Lafene Health Center, 1105 Sunset Ave., Manhattan, KS 66502 to communicate:

Mark at least one: ☐ Written Records ☐ Verbally

Mark at least one: ☐ RELEASE records to: ☐ OBTAIN records from:

Name & Address: _____

_____

Phone: _____ Fax:_____

Initial	The information to be disclosed consists of the following:		
	ALL - (this includes provider notes, phone notes, lab test, x-ray results, correspondence, medical history, immunizations, medications, etc.)		
	PARTIAL - (this may include labwork, notes from specific date, etc.) Please specify:		
	Documentation regarding my illness/injury for use in explaining class absence(s): ☐ include diagnosis ☐ do not include diagnosis		
OR select from the following to be disclosed.			
	Immunization Information: ☐ Complete ☐ Other:		
	Labwork and/or X-ray ONLY: Specify date:		
	TB Assessment		
Information listed below will be routinely disclosed unless specifically marked NOT to disclose for this authorization.			
	Alcohol/Drug Abuse Treatment records		Mental Health
	Abortion information		STD (Sexually transmitted disease)
	AIDS (Acquired Immune Deficiency Syndrome)		Sexual Orientation
	HIV (Human Immunodeficiency Virus)		Records from Outside Sources

Expiration: Specify the date this authorization expires: _____

NOTE: If no expiration date is specified, this authorization will expire one year from the date signed.

Purpose of Use/Disclosure: ☐ Continuation of Care ☐ Other: _____

Section C: Understanding

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 LHC may only disclose my past medical information and that this form does NOT authorize disclosure of any information related to future care I may receive unless otherwise indicated in the Expiration section. I understand that I may revoke this authorization at any time by delivering in writing a revocation to LHC, but if I do, it will not have any effect on actions LHC took in reliance on this authorization prior to receiving the revocation. I understand I am entitled to review any information to be disclosed and to have a copy of the same (at my expense).

Signature (no digital signatures): _____Date: _____

Relationship to Patient: _____

Allow 30 days for processing. No charges if records are sent to a healthcare provider.

Reviewed by:_____ Charges:_____ Date sent:_____

LAFENE HEALTH CENTER
KANSAS STATE UNIVERSITY
1105 SUNSET AVE
MANHATTAN KS 66502
PHONE: 785.532.6544
FAX: 855.618.0188
www.k-state.edu/lafene

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