FORT HAYS STATE UNIVERSITY
Forward thinking. World ready.

600 Park St.
LLO45 MU
Hays, KS 67601-4099
Phone: (785) 628-4293
Fax: (785) 628-4089

STUDENT HEALTH CENTER

MEDICAL RECORDS RELEASE

Authorization for the Use and Disclosure Protected Health Information

Patient Name: _____ Date: _____

Date of Birth: ____-____-____ Phone: _____

Current Address: _____ City: _____ ST: _____ Zip: _____

☐ **I hereby authorize:**

_____
Print name of physician or clinic where records are kept

_____
Address

_____ _____
Telephone Fax

to send my medical records to:

Fort Hays State University Student Health Center
600 Park St. - LL045MU
Hays, KS 67601.
Fax: (785) 628-4089

☐ I authorize **Fort Hays State University Student Health Center** to send my medical records to:

_____
Print name of physician or clinic where records are to be sent.

_____
Street Address

_____
City, State, Zip

Fax Number" _____

Records to be released:

☐ Most recent progress note or physical
☐ Medication List
☐ Most Recent PAP Results
☐ Diagnostic Test Results
☐ Immunization record
☐ Entire medical record

☐ All treatment records related to: _____

Include: ☐ HIV/STD results ☐ Drug and alcohol related records

Purpose of release:

☐ For treatment, payment or health care operations. ☐ Other _____

You may **revoke this authorization** in writing at any time. **Revocations do not apply to information that has already been disclosed or used before revocation has been received.**

This authorization expires one year from date of signing or on _____

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____
RELATIONSHIP TO PATIENT