Missouri Western State University
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Esry Student Health Center – Blum 203
Phone (816) 271-4495
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Authorization for the Use or Disclosure of Protected Health Information

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment or health care operations. In our Notice of Privacy Practices, we provided you information about how Missouri Western State University Esry Student Health Center can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Authorization:

_____ _____
Patient Name – First, Middle, Maiden, Last Student G Number

_____ _____ _____
Phone Number (including area code) Social Security Number Date of Birth

I authorize the Missouri Western State University Esry Student Health Center to:
Please check one of the following:

____**Obtain** protected health information from the following location via (circle one) phone, mail, or fax

____**Release** my MWSU Esry Student Health Center's protected health information to the following via (circle one) phone, mail, or fax

_____ _____
Name of Authorized Person, Agent, or Physician Phone Number including area code

_____ _____
Company, Hospital, or Practice Fax Number including area code

_____ _____
Address/Street City, State, Zip

Disclose the following information from my medical records:

_____ Clinical Progress Notes ___including ___ excluding primary care behavioral health
_____ History and Physicals _____ PPD testing, chest x-ray and treatment
_____ Women's Health visit(s) including Pap results _____ Immunizations
_____ Laboratory Reports (specify which lab tests)_____ _____ Titer
_____ Other

Specific purpose of request (how info will be used)_____

Covering the period from _____/_____/_____ to _____/_____/_____

Per Federal regulation 42 CFR Part 2 and MSMO 191-656 a specific authorization is required to release sensitive information. If such information is contained in a patient's records, that information will not be released unless specifically authorized below.

Specific data authorized for release	Patient Initials	Date	Provider Initials
HIV Testing and Results	_____	_____	_____
Psychiatry Notes	_____	_____	_____

You may revoke this Authorization in writing at any time, except to the extent that we have already released information in compliance with Authorization. Unless you revoke this Authorization in writing, this Authorization will expire 6 months from the date it was signed or upon expiration of the event for which the authorization was requested.

Upon request a copy of this Authorization will be provided to you after you sign it.

I, _____, have read the above information and authorized Missouri Western State University Esry Student Health Center to disclose the identified information to the persons and for the purpose described herein. I understand that by signing this document I release and discharge Missouri Western State University Health Center from any liability, and will hold Missouri Western State University Esry Student Health Center harmless for any release made pursuant to this Authorization.

Patient Signature_____ Date_____

Witness_____ Date_____