EASTERN KENTUCKY UNIVERSITY

Serving Kentuckians Since 1906

DIVISION OF STUDENT AFFAIRS
Student Health Services

John D. Rowlett Building Rm. 103
521 Lancaster Avenue
Richmond, Kentucky 40475-3102
(859) 622-1761
FAX: (859) 622-1767

Authorization for Release of Medical Information

By my signature below, I _____, hereby authorize
(Name and DOB)
_____ to release to _____ all medical
(Name of Health care facility) (Name of Health care facility)
records, including records of office visits and consultations, results of labs, x-rays, and other diagnostic tests, for the period from _____ to _____.

Without your specific approval, we cannot release records related to Sexually Transmitted Diseases (STD), Alcohol/Substance Abuse, Mental Health, and HIV/AIDS. Therefore, if you want these records included in the release, please initial next to the appropriate area(s) below.

_____STD _____Mental Health Information
_____HIV/AIDS _____Drug/Alcohol abuse and/or treatment

I understand that this authorization expires ninety (90) days from the date signed, unless otherwise specified, and that I may revoke the authorization by written notice, or verbal notice in person, at any time. The revocation will not apply to any information already released in reliance of this authorization. Furthermore, I understand that the Protected Health Information, the release of which I have agreed to, may be re-disclosed by the recipient to individuals or organizations not subject to HIPAA, and, therefore, may no longer be protected by HIPAA.

_____ Name of Student Date Signed _____

_____ Signature of Student Witness Name _____

_____ EKU ID No. Witness Signature _____