TAYLOR HEALTH AND WELLNESS CENTER

Missouri State University
901 S. National Avenue, Springfield, MO 65897
Telephone: (417) 836-4000 Fax: (417)836-4133 http://health.missouristate.edu

AUTHORIZATION TO DISCLOSE/RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with Federal and State laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), governing the use and disclosure of Protected Health Information (PHI).

I hereby authorize Taylor Health and Wellness Center to: **__disclose/release to ___obtain from**

_____

(name of person or organization) (telephone) (fax)

_____

(address) (city) (state) (zip)

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined by HIPPA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing, to Taylor's Privacy Officer. Unless revoked, this authorization will expire one year from date of signature or on the following date_____. If I choose to limit the information released, I understand that Taylor may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by Taylor. The University and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

[ ] **ALL** medical records without exception, including: clinical notes, lab testing (including HIV), mental health treatment, alcohol or drug abuse testing & treatment, genetic information and family history, sexually transmitted disease, consultations, secondary records, etc. or:

[ ] **PARTIAL** medical records which may include HIV testing & treatment, mental health treatment, alcohol or drug abuse testing & treatment, genetic information and family history, sexually transmitted disease & other sensitive information. Please specify parts and dates to be released:

[] progress notes _____ [] immunizations _____
[] x-ray reports _____ [] allergy _____
[] lab reports _____ [] physical _____
[] gyn records _____ [] consultations _____
[] other (specify) _____

for the purpose of _____

I authorize the release of my medical records as indicated above.

_____ _____
(signature of patient or legal guardian) (social security number)

_____ _____
(printed name) (date of birth)

_____ _____
(address) (city) (state) (zip)

_____ _____
(telephone number) (date)

_____ _____
(previous name under which records may be found) (witness) (date)

Note to Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws (including HIPPA) and prohibits you from further disclosure without the written consent of the person to whom it pertains. Charges may apply for copies of medical records.

A copy of this form will be filed in the above-named patient's PHI 2/2/2010