Esry Student Health Center – Blum Union 203
Missouri Western State University • 4525 Downs Drive
St Joseph, MO 64507
Phone: (816) 271-4495 ▪ Fax (816) 271-4498

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 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 via (circle one) phone, mail, or fax
OR
_____ **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
_____ Women's Health visit(s) include Pap results
_____ Laboratory Reports (specify which lab tests)
_____

_____ PPD testing, chest x-ray and treatment
_____ Immunizations
_____ Titers
_____ Other

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

This release covers the period from _____/_____/_____ to _____/_____/_____

Per Federal regulation 42 CFR Part 2 and MSMO 191-656 a specific authorization is required to released 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	Patients 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 this 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 authorize Missouri Western State University Esry Student Health Center to disclose the identified information to the person and for the purpose described herein. I understand that by signing this document I release and discharge Missouri Western State University and the Esry Student Health Center from any liability, and will hold Missouri Western State University and Esry Student Health Center harmless for any release made pursuant to this Authorization.

Patient Signature_____ Date_____

Witness_____ Date_____