

BUTLER UNIVERSITY HEALTH SERVICES
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____
Local Address: _____
City/State/Zip Code: _____
P0 _____ Phone No. (____) _____
Date of Request: _____ Date Needed: _____

Release of Records *

I authorize BUHS to **RELEASE** records to:

Provider/Facility: _____
Attn: _____
Address: _____
City/State/Zip Code: _____
Phone No: (____) _____
Fax No: (____) _____

-OR-

Obtaining Records

I authorize BUHS to **OBTAIN** records from the provider/facility named below:

Provider/Facility: _____
Attn: _____
Address: _____
City/State/Zip Code: _____
Phone No: (____) _____ Fax No: _____

NOTICE: Please note that once the requested records are provided to another party by BUHS those records may be subject to re-disclosure and not protected by this Authorization and certain Federal regulations dealing with the privacy of individually identifiable health information (45 CFR Part 164, Subpart E).

RELEASE OF RECORDS TO SELF:

I am requesting Butler University Health Services (BUHS) to release the records described below to myself as the Patient or Personal Representative of the Patient.

TYPE OF RECORDS REQUESTED:

The records requested are the following (check all that apply)

- Entire copy of medical records from (date) _____ to (date) _____
- Immunization History
- All medical records related to the specific illness or injury listed below:
_____ from (date) _____ to (date) _____
- Include records from other providers and facilities
- Other (be specific): _____
- I authorize BUHS to include information about the diagnosis and treatment of HIV.

THIS AUTHORIZATION EXPIRES (DATE): _____

(This date cannot be later than 60 days after the date of request)

PURPOSE FOR THIS REQUEST:

- At request of Patient
- At request of Patient's Personal Representative *
- Other (describe) _____

I authorize BUHS to release/obtain and make use of the Patient's protected health information and medical records described in this Authorization.

Signature: _____ **Date:** _____

*My authority to act as the Personal Representative of the Patient is based on the following:

SECURE FAX LOCATION: _____

FAX NUMBER _____

TO COMPLY WITH HIPAA, WE ARE VERIFYING THAT THE FAX NUMBER IS IN A SECURE LOCATION. WITHOUT THIS DECLARATION OF SECURITY, OUR OFFICE WILL NOT BE ABLE TO FAX PERSONAL HEALTH INFORMATION (PHI) TO THE NUMBER LISTED ABOVE,

I _____ **VERIFY THE ABOVE FAX NUMBER IS CORRECT AND THAT THE FAX MACHINE IS LOCATED IN A SECURE AREA.**

SIGNATURE _____ **DATE** _____

PRINT NAME _____

PHONE NUMBER WHERE YOU MAY BE REACHED _____

YOUR RIGHTS:

This Authorization may be revoked by signing where indicated below. Neither your subsequent revocation nor your refusal to sign this Authorization will be used as a basis to deny the Patient any treatment, service, or benefit otherwise available to the Patient as a BUHS student.

I **REVOKE** the above Authorization.

Signature: _____ Date: _____

ADMINISTRATIVE:

To be completed by an employee of Health Services

Date revocation received by the Health Services: _____

Date Request Received: _____

Circle one: Records Mailed Records Picked Up Records Faxed Records Denied

Employee Signature: _____

Date Request Completed: _____