KUTZTOWN UNIVERSITY
CONSENT TO RELEASE INFORMATION
Clinical Services Fax 484-646-4159
Health Administrative Services Fax 610-683-4635
Phone 610-683-4082 - PO Box 730, Kutztown, PA 19530

_____ _____/____/_____ _____ _____
Patient's Full Name (Please Print) Date of Birth KU ID Cell Number

☐ **I authorize Kutztown University Health & Wellness Services to <u>DISCLOSE</u> information in my medical record to:**

Name _____Organization/Agency: _____

Address _____City_____State_____ Zip _____

Phone _____ Fax _____

OR

☐ **I authorize the provider listed below to <u>RELEASE</u> information in my medical records to the following KU office:**

☐ **Clinical Services Fax: 484-646-4159** **OR** ☐ **Health Administrative Services Fax: 610-683-4635**

Name _____ Organization/Agency: _____

Address _____City_____ State_____ Zip _____Fax_____

1. **PURPOSE FOR DISCLOSURE**: ☐ Continuation of Care ☐ Payment of Claim ☐ Other _____

2. **EXTENT OF INFORMATION TO BE SENT**: ☐ All Dates of Treatment ☐ Date or Date Range_____

3. **TYPE OF INFORMATION TO BE DISCLOSED:** ☐ Treatment Notes ☐ GYN Information ☐ Lab Reports ☐ X-Ray Reports

☐ Immunizations / PPD (TB) & any related records Other_____

I understand that my record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health, HIV and/or AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information not be disclosed by initialing: _____ Alcohol/Drug abuse or dependency _____ Mental Health _____ HIV and/or AIDS _____ Sexual Assault

I understand this release is valid for 90 days or _____days (not to exceed 120 days) from the date it was signed. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information already has been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Health & Wellness Center. The staff of the Health & Wellness Center cannot be held legally liable for the interpretation of use by person/persons to whom they are released.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

_____
Signature of Patient **or** Legal Representative/Relationship Date

DISCLOSURE

This information has been disclosed to you from records protected by state and federal laws. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. Information related HIV/AIDS, alcohol and other drugs, and mental health and abuse issues are protected by law and a general authorization for the release of medical or other information is not sufficient for this purpose.

Heath & Wellness Center Staff Use Only: Records Sent/Released by: _____
Initials Date