Authorization to Use or Disclose Health Information

For patients to authorize release of information

Patient name: _____ Date of birth: _____

Address: _____

Telephone number: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The following individual(s) are authorized to make the disclosure:
   ☐ Kenyon College Health Center
   ☐ Other: _____ Fax: _____

3. The type of information to be used or described is as follows (check the appropriate boxes and include other information where indicated):
   ☐ History/physical exam ☐ Office notes ☐ Laboratory report ☐ Entire report
   ☐ Medication/allergy ☐ Radiological report ☐ Radiological images ☐ Other _____
   Date of service: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health and treatment for alcohol or drug abuse.

5. I understand health information in my record may contain documents from the other healthcare providers used in whole or in part by the hospital and affiliated clinical services.

6. The information above may be used or disclosed to the following individual or organization:

   Name: _____ Telephone: _____

   Address: _____ Fax: _____

7. This information that I am authorizing to be disclosed will be used for the following purposes:
   ☐ My personal records ☐ Other healthcare provider ☐ Other _____

8. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Kenyon College Health Center.

9. This authorization will expire:
   ☐ When this request is completed ☐ In _____ days, not to exceed 365 ☐ When claim is final

10. I understand that when the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

11. I understand authorizing the use or disclosure of the information identified above is voluntary. Signing this form has no impact on healthcare treatment.

12. I undertand that part or all of my request for access to my health information may be denied if state or federal laws apply to certain circumstances.

_____ _____
Signature of patient or legal representative Date

If signed by a legal representative or relative of the patient (i.e. guardian, power-of-attorney, executor), provide supporting documentation.

_____ _____
Signature of witness Date

Kenyon College
Health and Counseling Center

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