AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I request and authorize my health information to be released from: *(please check appropriate facility)*

☐ BSU Student Health Center ____________________

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Patient Name (first) Middle Initial Last

Street Address City State Zip

Date of Birth Telephone

Social Security Number

Admission, Visit and/or Treatment Dates

HEALTH INFORMATION TO BE DISCLOSED *(please initial all that apply)*

___ Physician Office Notes
___ Physician Office Dictation
___ Other *(specify)* ____________
____

___ Hospital Physician Dictation
☐ History & Physical
☐ Operative Report
☐ Consult
☐ Discharge Summary
☐ Other *(specify)* __________
____

___ Other Hospital Records *(specify)* ________________
____

___ Hospital/Physician Office Bill (please circle)
___ Pathology
☐ Other *(specify)*__________
____

___ Hospital Diagnostic Test Results
☐ Lab
☐ X-Ray Report
☐ EKG
☐ EEG
___ X-Ray Film
___ Chemical/Alcohol Treatment Records

___ Health Strategies
☐ Inital Evaluation
☐ Discharge Summary
☐ Therapy notes
☐ Other *(specify)*______
____

Psychotherapy Notes: If this authorization is to be used for disclosure of psychotherapy notes, it cannot be combined with any other authorization.

I understand that this information may include records relating to: Communicable diseases, including, but not limited to, Hepatitis, Sexually Transmitted Diseases, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related conditions, and any other disease; psychiatric, psychological or counseling treatment, or alcohol or drug abuse information, if any, as may be contained in the health records unless limited below.

Disclosure of my health information is to be limited or confined to the following specific information: ____

____

This information is to be disclosed to: ____

____

____For the purposes (s) of:

(must describe each purpose) ____

____

I understand that this authorization will remain in force for a reasonable time in order to effectuate the purposes for which it is given. I also understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken upon it. This authorization will automatically expire sixty days after the date of the authorization or on the following earlier date, event, or condition unless expressly revoked by me.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that Ball Memorial Hospital may charge for copies of the information to be disclosed under this authorization.

I further understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

Signature of Patient/Legal Representative   Date   Relationship of Legal Represntative

Witness Signature   Date

Ball State University Student Health Center
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Muncie, IN 47306
Fax: 765-285-1103