Authorization for the Use or Disclosure of Protected Health Information

University of Missouri-Columbia
Student Health Center
1020 Hitt Street, DC 800.00
Columbia, MO 65201

Record Release Numbers
Phone (573) 882-9109
Clinical Records Fax (573) 882-5370
Immunizations Only Fax (573) 884-8902

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 purpose other than treatment, payment or health care operations. In our Notice of Privacy Practices, we provided you information about how MU Health Care 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) (Student Number)

(_____)_____ _____ _____
(Phone Number including area code (Last 4 digits social security) (Date of Birth)

I authorize the University of Missouri Student Health Center (SHC) to:
Please check one of the following:

- ❑ **Obtain protected health information from the following location via (circle one): phone, mail or fax**
  or
- ❑ **Release my SHC 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) If applicable, indicate date of clinic appointment when these records will be needed.

The following information from my medical records:

- ❑ Clinical Progress Notes ___ including ___ excluding primary care behavioral health
- ❑ History and Physical
- ❑ Women's Health visit(s) including pap results
- ❑ Laboratory Reports (specify which lab tests): _____
  _____
- ❑ Other _____

- ❑ PPD testing, Chest x-ray and treatment records
- ❑ Immunizations
- ❑ Titers

Dates of treatment to be released: _____/_____/_____ to _____/_____/_____

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

See Reverse Side

Release Complete: # Pages _____
Faxed _____ Picked Up _____
US Mail _____ Campus Mail _____
By _____Date _____

Per Federal regulation 42 CFR Part 2 and MSMO 191-656 a specific authorization is required to release "sensitive" information. If such information is contained in a patient's record, that information will not be released unless specifically authorized below.

Specific data authorized for release	Patient Initials	Date	Provider Initials
HIV Testing and Results	_____	_____	_____
Substance Use Intervention Notes	_____	_____	_____
Psychiatry Notes	_____	_____	_____
Psychotherapy Notes*	_____	_____	_____

*Psychotherapy Notes are detailed notes that are recorded in any medium (paper or electronic) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session.

Check one: yes □ no □ I understand that if the protected health information being disclosed herein *contains information regarding drug and/or alcohol abuse, psychiatric care, sexually transmitted* infections, including AIDS, and Hepatitis B or C testing or results, I agree to their release.

- 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.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or entity having received it, and may no longer be protected by federal or state privacy regulations or laws.
- I understand that my treatment or care from the Student Health Center is not conditioned on my signing this authorization and that I will not be denied medical treatment or care if I do not sign this authorization. I also understand that I can inspect or copy the protected health information to be used or disclosed pursuant to this authorization.
- I understand that this authorization may be revoked by me at any time, by notifying in writing the Student Health Center directed to: Dr. Susan Even, MU Student Health Center, 1101 Hospital Drive, DC 800.00, Columbia, MO 65212. I understand that any use or disclosure of the protected health information pursuant to this authorization prior to the effective date of the revocation will not be affected by the revocation.
- I understand that a photocopy or facsimile copy of the authorization will be as valid as the original. I am entitled to receive a copy of this authorization.
- Student Health may assess appropriate and reasonable fees for copying such information. Such fees will comply with all state and federal laws. See Fee Structure below.

Date: _____ By: _____

Signature of Patient / Legal Representative

Please allow 5-7 working days to process your request

Immunization records

- No charge

Enrolled student with health fee:

- Copies sent to another medical facility or self – no charge
- Copies sent to insurance company or attorney - $22.01 processing fee plus $.52 per page. This will be charged to the student's account. If the insurance company or attorney pays the charges, the student account will be credited.

Enrolled student without health fee:

- Copies sent to self will be charged a $25.00 processing fee, which may be charged to the student account.
- Copies sent to another medical facility – no charge.
- Copies sent to insurance company or attorney - $22.01 processing fee plus $.52 per page. This will be charged to the student's account. If the insurance company or attorney pays, the student account will be credited.

Student no longer enrolled at University of Missouri – Columbia

- Copies sent to self or another medical facility – prepaid processing fee of $25.00
- Copies sent to insurance company or attorney will be charged $22.01 processing fee and $.52 per page. This will be billed and collected by the Student Health Center.

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