



**GENERAL AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient's First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Student ID #: \_\_\_\_\_ Sex: F  M

**Purposes of Disclosure (check all that apply):**

- Changing Physicians  Patient Request
- Needed for Treatment  Billing Issues
- Other (specify): \_\_\_\_\_

**Description of Information to be Disclosed (check all that apply):**

- All Protected Health Information  Problem, Med & Immunization Lists  Operations/Delivery Reports
- Nursing & Physician Notes  Lab Tests  CATH or Intravascular Reports
- Therapy & Medications Notes  Imaging Reports (X-Ray, MRI, CT)  Itemized Bill / UB92
- Other (specify): \_\_\_\_\_

**I authorize Rockhurst University to disclose the above requested information to:**

Name of Agency or Person: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Patient Acknowledgements:**

This authorization shall be effective for a period of one year from the date it is signed, unless earlier revoked by me. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider to which this authorization is directed. I understand this authorization is strictly voluntary and that the health care provider to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information may no longer be protected by federal privacy laws. Any facsimile, copy or photocopy of this authorization shall authorize the release of the records requested herein.

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian or Other Representative (if applicable) Date Relationship to Patient

***SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW:***  
 In addition to the authorization and other provisions contained above which are hereby incorporated by this reference, I authorize Rockhurst University to disclose to \_\_\_\_\_:

1. Alcohol/Drug Abuse Information  2. Mental Health/ Psychological Testing Information  3. HIV-Related/AIDS Testing-Related Information

**Notice to Receiving Agency/Institution/Therapist:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you 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 or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for these purposes. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian or Other Representative (if applicable) Date Relationship to Patient

**For Rockhurst University Use Only:**  
Information sent on: \_\_\_\_\_ By: \_\_\_\_\_ Via: Fax  Mail