University of Missouri – Kansas City
Student Health and Wellness

5110 Oak St., Brookside 51, Suite 237 | Kansas City, MO 64112 | 816.235.6133 (Phone) | 816.235.6565 (FAX)

Consent/Authorization for Release of Information

All sections of this consent form MUST be completed to be valid in accordance with Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164

Patient's Name _____ DOB _____/_____/_____ UMKC ID # _____

Parent/Legal Representative (Patients under 18 years of age) _____

I consent for UMKC Student Health and Wellness to:

Check only one. Draw line through items not authorized to be shared (example: ~~Receive my protected health information from:~~).

◯ Release / Disclose my protected health information to:

◯ Receive my protected health information from:

◯ Exchange my protected health information with:

_____
Name of Person / Provider / Facility

_____
Address

_____
City State Zip

(_____) _____ (_____) _____
Phone Number Fax Number

I consent for the following protected health information to be released: ◯ All Health Records **OR** ◯ Other _____

From: ◯ All past, present and future encounters/visits **OR** ◯ Specific Date(s) _____/_____/_____to _____/_____/_____

I consent for the following sensitive protected health information to be released from my medical records:

Initial all items that you authorize. Draw line through items not authorized to be shared (example: ~~Drug/Alcohol Treatment~~).

_____ Mental Health Testing and/or Treatment _____ Drug/Alcohol Treatment _____ Sexually Transmitted Infection Testing and/or Treatment
(Includes Hepatitis B, Hepatitis C, and HIV/AIDS)

The purpose for the release of my protected health information is for:

◯ Continuity of Care ◯ Insurance ◯ Legal ◯ Personal ◯ Other _____

By signing this consent form, I understand that:

- Requests for copies of medical records may be subject to copying fees.
- I have the right to revoke this consent at any time. Revocation must be made in a formal written request to the Student Health and Wellness Privacy Officer at the address listed on this consent. Revocation will not apply to information that has already been released in response to this consent.
- This authorization will expire **one year** from the date signed **unless** an earlier expiration date is indicated here: _____/_____/_____
- Student Health and Wellness cannot prevent redisclosure of your information by the person/organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release UMKC Student Health and Wellness from any and all liability resulting from a redisclosure by the recipient.
- My right to healthcare treatment is not conditioned on this authorization, unless disclosure or use of the information is necessary for treatment.
- My signature indicates that I have read and understand this form, and authorize the release of my records as described above.

_____ _____/_____/_____
Patient/Parent/Legal Representative Signature **Date**

(For Legal Representative Signatures, Student Health and Wellness requires a copy of the documentation that declares such authority.)

FOR OFFICE USE ONLY — FAX STAMP

FOR OFFICE USE ONLY — POSTAL

Transfer of records completed by: _____
Full Name of Staff Member

Transfer of records completed on: _____/_____/_____

REVISED 07/02/2015