



EASTERN KENTUCKY UNIVERSITY

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DIVISION OF STUDENT AFFAIRS
Student Health Services

John D. Rowlett Building
521 Lancaster Avenue
Richmond, Kentucky 40475-3102
(859) 622-1761
(859) 622-1767 fax
studenthealthservices@eku.edu •
www.eku.edu

By my signature below, I _____, hereby authorize
(Name and DOB)

_____ to release to _____ all medical
(Name of Health care facility) (Name of Health care facility)

records, including records of office visits and consultations, results of labs, x-rays, and other diagnostic tests, for the period from _____ to _____.

Without your specific approval, we cannot release records related to Sexually Transmitted Diseases (STD), Alcohol/Substance Abuse, Mental Health, and HIV/AIDS. Therefore, if you want these records included in the release, please initial next to the appropriate area(s) below.

_____ STD _____ Mental Health Information
_____ HIV/AIDS _____ Drug/Alcohol abuse and/or treatment

I understand that this authorization expires ninety (90) days from the date signed, unless otherwise specified, and that I may revoke the authorization by written notice, or verbal notice in person, at any time. The revocation will not apply to any information already released in reliance of this authorization. Furthermore, I understand that the Protected Health Information, the release of which I have agreed to, may be redisclosed by the recipient to individuals or organizations not subject to HIPAA, and, therefore, may no longer be protected by HIPAA.

Name of Student

Date Signed

Signature of Student

Witness Name

S. S. #

Witness Signature

