



EASTERN KENTUCKY UNIVERSITY

Serving Kentuckians Since 1906

DIVISION OF STUDENT AFFAIRS
Student Health Services

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Richmond, Kentucky 40475-3102
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FAX: (859) 622-1767
studenthealthservices@eku.edu
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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 _____

Based on reliable picture identification provided by the above named individual, I can attest to his/her identity, and can verify the
authenticity of his/her signature, signed before me this _____day of _____, _____.
Date Month Year

I am a duly licensed Notary Public in the state of _____.
My License expires: _____.
Name of Notary Public: _____.
Signature of Notary Public: _____.

Seal:

