Patient Authorization to Send or Receive Protected Health Information

Asbury University Student Health Services

1 Macklem Dr. Wilmore KY 40390 ● Ph. 859-858-3511 Ex. 2277 ● Fax 859-858-0003

I, ___________________________, understand Asbury University Health Service is authorized by me to ***send / receive*** *(circle one)* my Protected Health Information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be ***sent / received*** *(circle one)*, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize Asbury University Health Service to ***send / receive*** (circle one) my Protected Health Information as described on this form ***to / from*** (circle one) the recipient(s) listed below. I understand that when the information is used or disclosed as requested in this authorization, it may be subject to re-disclosure by the recipient and may no longer be Protected Health Information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the information to be ***sent / received*** *(circle one)*:
(please check all that apply:)

- [ ] The entire medical record
- [ ] Immunization records
- [ ] Medical Data/Information as related to:
  - [ ] Specific condition(s): ______________________________
  - [ ] Specific professional service(s): ______________________________
  - [ ] Specific medication(s): ______________________________
  - [ ] Specific date(s): ______________________________

Purpose(s) of the information:

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This authorization permits Asbury University Health Service, One Macklem Drive, Wilmore, KY 40390 to ***send / receive*** (circle one) the Protected Health Information ONLY ***to / from*** (circle one) the following person, address or fax number:

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The patient has a right to revoke this authorization in writing, except to the extent that action has already been taken on this authorization. In order for the revocation of this authorization to be effective, Asbury University Health Service must receive the revocation in writing. The revocation must include the patient's desire to revoke this authorization and:

- The patient's name and address,
- The effective date of this authorization,
- The recipients of the Protected Health Information according to this authorization,
- The date of the revocation, and
- The patient's signature.

ALL revocations must be sent to Asbury University Health Service to the attention of the Privacy Officer, Carol Amey, R.N., either in person, by mail or fax (859-858-0003) and are not effective until received by the Privacy Officer.

This authorization shall expire on ______________________________. After this date, Asbury University Health Service can no longer use or disclose the patient's Protected Health Information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

______________________________	__________________	______________________________
Patient's Signature	Date	Phone Number
______________________________	__________________	______________________________
Birthdate	Last year at Asbury	Witness' Signature