Pittsburg State University
University Counseling Services

Bryant Student Health Center
1701 S Broadway St. ◆ Pittsburg, KS 66762
www.pittstate.edu/health
Phone number: 620-235-4452

Consent for Release of Information

UNDER HIPAA REGULATIONS, THIS RELEASE IS ONLY VALID IF ALL BLANKS ARE FILLED IN.

From:	**To:**
Name/Agency:	Name/Agency:
Address:	Address:
Phone: Fax:	Phone: Fax:

THE REQUESTED INFORMATION WILL BE USED FOR (CHECK ONE OR MORE BELOW):

☐ For treatment, payment or health care operations ☐ Other: _____

Information to be disclosed will be for the past 3 years only OR for this date range: _____to_____

☐ Entire Record: Dates of Contact, intake, progress notes, treatment plan, diagnosis, prognosis, closing summary, recommendations, current needs, and functioning level.

☐ Summary of Treatment letter from counselor ☐ ADHD/ Learning Disabilities

☐ Psychological Evaluation/Testing Reports ☐ Other: (describe)_____

Include: ☐ **HIV/STD results** ☐ **Drug and alcohol related records**

PLEASE DO NOT INCLUDE: _____

I understand that once the uses/disclosures have been made as permitted by this form, the records/information may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that will not affect my ability to obtain treatment. I understand that BSHC may only disclose my past mental health information and that this form does NOT authorize disclosure of any information related to future care I may receive. I understand that I may revoke this authorization at any time by delivering in writing a revocation to Pittsburg State University, Bryant Student Health Center, but if I do, it will not have any effect on actions the Clinic took in reliance on this authorization prior to receiving the revocation. I authorize the use/disclosure of the records/information described above.

This authorization expires one year from date signing or on: _____

_____	_____	_____
Patient signature or parent, guardian or authorized representative	Printed Name of Patient	Date
_____	_____	_____
Phone Number of Patient, parent, guardian or authorized representative	Patient's Date of Birth	PSU ID #

Please allow ten business days for processing

☐ ROI request sent _____ *(Initials & Date)* ☐ **Faxed** ☐ **Mailed**	Charges: $ _____Reviewed by: _____
☐ Documents sent _____ *(Initials & Date)* ☐ **Faxed** ☐ **Mailed**	No charges if records sent to a health care provider

Pittsburg State University – Student Health Services
1701 S Broadway, Pittsburg, KS 66762
FAX NUMBER: 620-235-4985 (Medical Records)