

Pittsburg State University Student Health Services
1701 South Broadway Pittsburg, Kansas 66762
620-235-4452

Permission to Disclose Information to those involved in my Care

I hereby authorize PSU Student Health Services to disclose the following Protected Health information with me over the phone about my medical care. (This form does not apply to University Counseling Services):

- | | |
|--|---|
| <input type="checkbox"/> Appointment times and dates | <input type="checkbox"/> Test results |
| <input type="checkbox"/> Tests that have been received | <input type="checkbox"/> Other Health Information |

- | | | | |
|---|----------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Home Telephone _____ | Leave Message? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Cellular Phone _____ | Leave Message? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I also give permission for you to discuss the marked information with the following persons because they are also involved with my health care or payment. I understand that the individuals listed below will not be contacted by the Bryant Student Health Center without my permission except in the case of a medical emergency. If I give permission by listing individuals below, my information may be released to these individuals if they contact the Bryant Student Health Center. (You may leave this section blank if you do not want us to share information with anyone.):

Information to be Shared:

- Appointment times and dates
- Tests that have been received
- Test Results
- Other Health Information
- Billing and payment information

Exceptions:

- Sexual Health
- STD Testing
- HIV Testing
- Contraceptives
- Other _____

Name/Names: _____	Relationship:	<input type="checkbox"/> Parent	<input type="checkbox"/> Child/Children
Home Telephone _____		<input type="checkbox"/> Spouse	<input type="checkbox"/> Other _____
Cellular Phone _____	Work Phone _____		

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Cellular Phone _____	Work Phone _____		

Print Patient Name

Student ID #

Patient Signature

Date