Butler College Health Service
5000 Bldg., Room 5250
715 E. 13th Street
Andover, KS 67002
316-218-6282 or Fax: 316-218-6007

Authorization

PATIENT'S FULL NAME: _____ Date of Birth: _____

I authorize Butler College Health Service to release my:

- ❑ Lab tests and/or results
- ❑ X-ray
- ❑ Immunization record
- ❑ Physical exam results
- ❑ Other information as directed: _____

To: _____
Name of authorized recipients of class of recipients to which information may be released

Via

Fax to: _____
Name Fax number

Mail to: _____
Name Address

Telephone to: _____
Name Telephone number

Pick up in person _____

For the purposes of:

_____

This authorization is effective on the date signed and continues until _____.
Provide date

I understand the following:

a) If I refuse to authorize the release of my health information, Butler College Health may not refuse to treat me.

b) I may revoke this authorization at any time by notifying Butler College Health Service.

c) The information disclosed pursuant to this authorization may be redisclosed by the recipient and therefore may be outside the protection of Federal rules on privacy.

I have read the above and understand it.

_____
Signature

_____
Printed Name

_____
Date

_____
Witness Signature

_____
Printed Name

_____
Date