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 Name: _____

Other Names: _____

Date of birth: _____ Phone Number: _____

I authorize: _____

To release my medical records containing the following information:

- ❑ Name
- ❑ Address
- ❑ Telephone Number
- ❑ Email address
- ❑ Social Security Number
- ❑ Insurance Policy Information
- ❑ Diagnosis or health status
- ❑ Other information about my health status, described as follows: _____
- ❑ Laboratory tests or results
- ❑ X-rays or reports
- ❑ Immunization record
- ❑ Physical examination results

TO:

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5000 Bldg., Room 5250
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Andover, KS 67002
316-218-6282
Fax: 316-218-6007

For the purpose of: _____

This authorization is effective for one (1) year from date of signature. I may revoke this authorization at any time by notifying the stated provider. 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 statements and understand them.

Signature	Witness Signature
Printed Name	Printed Name
Date	Date