Student Health
T: (502) 597-6271
F: (502) 597-6565

Counseling
T: (502) 597-6969
T: (502) 597-6970
F: (502) 597-6565

Student Health Services
400 East Main Street
Frankfort, KY 40601

Consent to Release Confidential Health Care Information

1.Patient

Name-Last, First, MI			DOB	KSU Class
Street Address				
City	State	ZIP	Phone	

2. Release Information FROM:
__ KSU Student Health Services
__ KSU Counseling
Treatment Provider (if applicable)
__ Other (complete box below):

3. Release Information TO:
__ KSU Student Health Services
__ KSU Counseling
Treatment Provider (if applicable)
__ Other (complete box below):

Name (i.e., Health Facility, Physician, etc.)		Name (i.e., Health Facility, Physician, etc.)	
Street Address		Street Address	
City State Zip		City State Zip	
Telephone #	Fax #	Telephone #	Fax #

4. Information to be Released (Check All That Apply)
__ Complete Copy of All Records
__ Immunizations
__ Lab Results
__ Progress Notes: all __
Or specified dates _____
__ Other (specify):
_____
__ Attendance/Participation in Counseling
__ Psychotherapy notes
__ Result of evaluations
__ Clinical summary letter or email
__ Verbal clinical summary

__ Check here if ONLY Records May Be Released (i.e. conversations, including those intended for clarification or follow-up, are not authorized)

5. Purpose for Disclosure (check All That Apply)
__ Facilitate coordination of health care
__ Academic Adjustment or Accommodations
__ Personal
__ Other (specify): _____

I understand that I am giving my permission to the above named treatment provider or other named third party for disclosure of confidential health care information, including both records and discussions pertaining to those records, unless otherwise noted in Section 4 above. This consent is not a condition for treatment at the Kentucky State University Student Health Services or Counseling. I also understand that I have a right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or third parties to who disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may be subject to re-disclosure by the recipient and no longer protected. I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient (or parent/guardian if under 18) **Date** *(Document expires one year from this date)*