

Butler College Health Services
1100 Bldg, Room 11-165
901 South Haverhill Rd
El Dorado, KS 67042
316-322-3371 or Fax: 316-323-6850

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