Form UCC 103

Morehead State University
Counseling & Health Services
Authorization for Release of Information

Fill in answers to each item below: The patient or patient's legal representative must sign this completed authorization before any information will be released.

Patient Name: (*Last*)_____(*First*)_____(*Middle*)_____

Address: _____

Phone: _____Date of Birth: _____ SSN or MSU Eagle ID: _____

I authorize **Counseling & Health Services** to: _____release _____ request medical information.

Name of facility/agency, or individual to receive/release information: _____

Address: _____

City/State/Zip: _____

Information to be released/requested covers the time period(s) of treatment on:

_____

Deliver or mail completed form to:
Morehead State University
Counseling & Health Services
112 Allie Young Hall
Morehead, KY 40351
Fax: (606) 783-9106

I understand that released/requested information will be used for the purpose of: _____

1. Information to be released/requested: (Check all appropriate boxes)
   ___All Records ___Immunization Records ___TB Screening Results ___Mental Health Records
   ___Patient Visit Notes ___Copy of Physical (Specify)_____
   ___Other (Specify) _____
2. I authorize the release of information pertaining to the diagnosis or treatment of AIDS including the results of HIV tests.
   ___YES ___NO ___Not Applicable

I understand this consent can be revoked (in writing) at any time except to the extent that disclosure made in good faith has already occurred. I also understand this authorization will expire automatically sixty (60) days from the date below unless otherwise specified _____ _____. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.
The facility, its employees and officers and attending medical practitioner(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.
I understand that I may refuse to sign this authorization, and that if I do refuse, this will not affect my ability to obtain treatment.

Date: _____ Signature:_____

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:

Signature of Legal Representative: _____

___Minor
___Incompetent
___Deceased

Relationship: _____

Signature of Witness: _____

SEAL *Notary: _____

Date: _____ My Commission Expires:_____

***Authorization MUST be notarized if requesting records from Counseling & Health Services and request is not made in person.**