Student Health Center
University of Missouri Health

Student Health Center
University of Missouri
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Columbia, MO 65212

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immunizations@health.missouri.edu

Authorization for the Use or Disclosure of Records for Compliance

(for use by Health Profession students only)

Name (first, middle, maiden, last) _____

Student number _____ Phone (including area code) _____

SS# (last four digits) _____ Date of birth _____

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purpose other than treatment, payment or health care operations. In our Notice of Privacy Practices, we provided you information about how University Health Care can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Authorization.

I authorize the University of Missouri Student Health Center (SHC) to release my SHC protected health information to the following location via (check one):

❑ Phone ❑ Mail ❑ Fax ❑ Secure email _____

Name (of authorized person, agent or physicain) _____

Company, hospital or practice _____ Phone (including area code) _____

Fax (including area code) _____ Address (street, city, zip) _____

❑ Tuberculosis Testing information including TST/IGRA and chest X-ray and treatment records ❑ Immunizations

❑ Antibody titers ❑ Urine drug screen

I hereby release the Curators of the University of Missouri, its officers, agents, and employees from any and all liability, claims or causes of action for providing the medical information requested. This authorization expires in six (6) months unless sooner revoked in writing.

Patient signature _____ Date _____

Office use only

Release Complete: # Pages _____ Faxed _____ US Mail _____

Secure Email _____

By _____ Date _____

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