AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AT DKU CAMPUS HEALTH CLINIC

Mailing Address: DKU Campus Health Clinic, No.8 Duke Ave.
Kunshan, Jiangsu, China. (+86)51236657228

Patient Name: _____

Medical Record Number: _____

Date of Birth:_____

DKU Net ID: _____

I authorize and request the DKU Campus Health Clinic to release information from the medical records of the Patient listed above to:

_____

(Person/Physician/Entity TO RECEIVE records-please be specific)

to be mailed to: _____

(Address)

☐ By electronic access to medical and claims information

☐ Through oral communication with healthcare providers regarding treatment, care, or payment

The specific information for the following dates of service: _____

INFORMATION TO BE DISCLOSED (check the appropriate boxes and include other information where indicated):

☐ Summary Health Information
(History and Physical, Radiology, Pathology, Laboratory, and Dictated notes)

☐ History and Physical (e.g., Doctor visit) ☐ Laboratory Reports

☐ Radiology Reports ☐ Immunization Records

☐ Physical Therapy Notes

☐ Comprehensive Record

☐ Other: _____

☐ Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, Status, symptoms, prognosis, and treatment to date

☐ Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:

☐ Sharing with other health care providers as needed

☐ Insurance processing

☐ Legal reasons

☐ Personal use

☐ Other: _____

This Authorization shall cover actions by and for the DKU Campus Health Clinic, and all of its respective employees, workforce, and business associates. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the DKU Campus Health Clinic. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be re-disclosed by the recipient and China's privacy laws may not protect the re-disclosure. I understand authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event: _____ _____
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____

Date Signature of Patient* or Legal Representative* Signature of Witness

***If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-Patient's behalf.** By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.