Washington University in St.Louis

Authorization for the Use and Disclosure of Protected Health Information

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Last Name _____ First Name _____ Date of birth _____/_____/_____

Email Address _____ Student ID# _____ Phone # _____

Address _____ City _____ State_____ Zip Code_____

2. RELEASE RECORDS ☐ FROM or ☐ TO (check one) ⇔ RELEASE RECORDS ☐ FROM or ☐ TO (check one)

Student Health Services
One Brookings Drive-Campus Box 1201
Saint Louis, MO 63130-4862
Phone: 314-935-6666 Fax: 314-935-8515 Website: shs.wustl.edu

Name/Organization _____
Street Address _____
City/State/Zip _____
Phone _____/_____ Fax _____/_____

☐ Mail records ☐ Fax Records ☐ Discuss verbally

▶ A fee may be associated with your request for release of records

3. INFORMATION TO BE RELEASED FROM YOUR GENERAL MEDICAL RECORD:

	Date of Service/Content		Date of Service/ Content
☐ Office visit	_____	☐ Radiology report	_____
☐ GYN visits	_____	☐ Xray	_____
☐ Lab Work	_____	☐ Billing receipts	_____
☐ Immunizations	_____	☐ Entire Record	_____
☐ Physical Therapy Notes	_____	☐ Other	_____

▶ If specific date(s) are not indicated, all records in the category marked will be released.

4. INFORMATION TO BE RELEASED FROM YOUR ☐ COUNSELING AND/OR ☐ PSYCHIATRIC RECORD:

	Date of Service/Content		Date of Service/Content
☐ Office visit	_____	☐ Drug/Alcohol Issues	_____
☐ Medication history	_____	☐ Entire Record	_____
☐ Assessment	_____	☐ Attendance	_____
☐ Treatment Plan	_____	☐ Other	_____
☐ Progress Notes	_____		_____

5. INFORMATION IS TO BE USED FOR:

☐ Academic Considerations
☐ Contact with Referral Source
☐ Continuity of Treatment
☐ Family Involvement
☐ Collaboration with other campus organizations
☐ Other _____

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of protected health information as defined under the Health Insurance Portability and Accountability Act (HIPAA). I understand that once my protected health information is used/disclosed pursuant to this authorization, the information may no longer be protected by the privacy regulations and may be subject to redisclosure by the recipient(s). I understand that I have the right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my health information and such use and/or disclosure has already occurred. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Washington University, nor will it affect my eligibility for benefits. I understand that unlike some other protected health information, I may not have an unqualified right to inspect and copy my mental health records as is explained in the Notice of Privacy Practices.

This authorization shall expire: ___ in 6 months from the date I sign this authorization; or
___ Other (describe) _____

6. SIGNATURE OF PATIENT/CLIENT: I certify that I have reviewed a copy of this authorization, understand the above statements, and consent to the disclosure of my health record for the purpose and to the extent stated above.

▶ Signature _____ Today's Date _____
Name of Personal Representative _____ Relationship to Individual _____

Individual Unable to sign due to: _____. Patient/Client gave verbal permission.

Signature of Witness _____ Date Signed _____

To Be Completed by Washington University

Method of Identity Verification:

For Individual:

___Individual known to Washington University

___Picture ID of individual

___Match of individual signature with Washington University documents

For Requesting Party other than Individual: ***(Both required)***

___Picture ID of requesting party

___Signed letter of authorization or completion of this form by individual

Signature of Washington University Staff Member Verifying Identity: _____

Print Name:_____ Title: _____

Date: _____

(Revised 4 07)