Washington University in St.Louis

Authorization for the Use and Disclosure of Protected Health Information

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION 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: 314-696-1214 Website: habif.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 10/2020)