Habif Health and Wellness Center
STUDENT AFFAIRS AT WASHINGTON UNIVERSITY

One Brookings Dr; MSC 1201-323-100
St. Louis, MO 63130-4862
Phone 314.935.6666
Medical Records Fax: 314.696.1214

Authorization for the Release of Health Information

Student Information

Name: _____ Date of Birth:_____

Student ID #: _____ Phone # _____

email: _____

Enrollment Status:

[ ] Currently Enrolled

[ ] Last Date Attended: _____ (mm/yyyy)

Previous Names Used_____

Who has the information you need

I Authorize _____ at Habif Health and Wellness Center to

Name of Provider

[ ] Release health information -> **TO:** [ ] Request health information -> **FROM:**

Where do you want the information sent/ received

[ ] WashU Cares [ ] Study Abroad Office [ ] Disability Resources

[ ] Student Conduct [ ] Self [ ] Outside Agency/Individual

Individual Name: _____

Agency Name:

_____

(below information only needed for "self" or "outside agency/individual")

Address:

_____

Street City State Zip

Phone: _____ Fax: _____

Email: _____

Method of Release

(choose only one)

[ ] Mailed [ ] Faxed [ ] Electronic Copy [ ] Picked up [ ] Verbal

Information to be sent (check all that apply)

Information to be Released/ Received **Date(s) of Service: _____**

General Medical Record

[ ] Office Visits [ ] Lab Results [ ] Pap/Annual Exam (most recent)

[ ] Immunizations [ ] Radiology reports [ ] Billing

[ ] Other requests/limitations _____

[ ] All health information in my medical records, to include x-ray and laboratory

Mental Health Record: **Counseling Services and/or Psychiatric Services**

[ ] Entire Record [ ] Session Attendance [ ] Medication history

[ ] Treatment Plan [ ] Drug/Alcohol Issues [ ] Progress/Session Notes

[ ] Intake Assessment

[ ] Other requests/limitations _____

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Sensitive Information	**I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDS), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment, or genetic counseling. I give my specific authorization for these records to be released:** ( ) Mental Health/Developmental Disabilities diagnosis and Treatment ( ) HIV/STD Testing and Treatment ( ) Drug/Alcohol Use diagnosis and treatment ( ) Genetic Testing
Purpose of Disclosure	( ) Academic Use ( ) Continuity of Treatment ( ) Family Involvement ( ) Contact w/Referral Source ( ) Legal ( ) Collaboration w/other campus organizations ( ) Other: _____
Email Encryption	Email is not a secure means of communication. We will encrypt e-mail communications of your records unless you tell us you prefer us to use unencrypted email. If you prefer we NOT ENCRYPT our communications to you, please initial here: _____

Processing Your Requested Information:
Habif Health & Wellness may charge a fee for copying of requested health information plus postage for mailing the copies to you. Habif Health & Wellness will respond to your request for health information within 30 days of receipt of your request. If we require additional time to respond to your request, we will contact you to inform you of this extension time.

Authorization is valid either 90 days from the date of signature (if not otherwise specified) OR as specified by selecting one of these options:

( ) This authorization expires on the following date: _____
( ) This authorization expires due to the following event or special condition: _____

- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.
- I understand that once my information is used and/or disclosed pursuant to this authorization, it may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient(s).
- This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time by sending a written notice of revocation to Habif at the address or fax number on the top of this form.

Signature: _____ Date: _____

Relationship to Patient: _____

Additional Documentation Attached:

( ) Power of Attorney ( ) Guardianship Paperwork ( ) Other: _____