Habif Health and Wellness Center

STUDENT AFFAIRS AT WASHINGTON UNIVERSITY

Habif Health & Wellness
One Brookins Dr, Campus Box 1201
St. Louis, MO 63130
Phone: 314.935.6666 | Fax: 314.696.1214

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION BY INDIVIDUAL PATIENTS

Please check (✓) the appropriate box(es) (☐) and fill in the blank(s) as needed.

Individual Patient Name (Last, First): ______________________________

Patient's Date of Birth: ______________________

Student ID # ______________

Enrollment Status
☐ Currently Enrolled, *or*
☐ Date last attended: __________ *(mm/yyyy)*

Telephone Number: (Home) (   )______________________

☐ Dr(s). ______________________

☐ All Habif Health & Wellness Providers

Previous Names Used: ______________

Please Check Specific Information Requested

General Medical Record

☐ All Records
☐ Abstract of medical record **(Office Notes, Procedures, Images, & Test Results Only)**
☐ Office Visits/Nurses Notes
☐ Radiology Reports
☐ Laboratory Results
☐ Immunizations
☐ Pap/Annual Exam (most recent)
☐ Itemized Billing Statement

Mental Health Record

☐ Entire Mental Health Record
☐ Intake Assessment
☐ Session Attendance
☐ Drug/Alcohol Issues
☐ Progress/Session Notes
☐ Treatment Plan
☐ Medication History

☐ Other (specify) ______________________________

Date(s) of Treatment: ☐ Specific Dates:____________thru____________ ☐ All dates

In what format would you like to receive your records: ☐ Paper Copy ☐ Electronic Copy

Release or Mail To:

Individual/Legal Guardian/Personal Representative ______________________________

Street Address ______________________________

City, State and Zip Code ______________________________

Phone Number of Individual Receiving Records if not Patient: ______________________

Email Address ______________________________

Email is not a secure means of communication. We will encrypt email 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:

Washington University Physicians may charge a fee for the copying of requested health information plus postage for mailing the copies to you. If you would like a copy of your record to be provided on portable media such as a CD or USB drive, we may charge you the actual cost of the portable media.

Washington University Physicians will respond to your request for health information within 30 days of our receipt of your request. If, however, your health information is not readily accessible by Washington University Physicians or is maintained in an off-site storage location, Washington University Physicians has an additional 30 days to respond to your request. If we require additional time to respond to your request, we will contact you to inform you of this extension of time.

We appreciate your patience while we process your request.

____ Date:____________

Signature of Patient/Legal Guardian/Personal Representative