Washington University in St.Louis

Authorization for the Use of Disclosure of Protected Health Information

1. I AUTHORIZE THE FOLLWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORDS OF: ☐ Student ☐ Employee

   Last Name: _____ First Name_____ Date of birth ___/__/____
   Program _____ Matriculation Date _____ Graduation Date _____
   Email address_____ Student ID # _____ Phone #_____
   Address _____ City _____ State _____ Zip Code _____

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

   WUSM Health Service
   660 S. Euclid, Box 8030
   St Louis, MO 63110
   Phone: 314-362-3523 Fax: 314-362-0058

   Name/Organization_____
   Street Address _____
   City/State/Zip_____
   Phone_____ Fax _____
   Email _____

   ☐ Mail records ☐ Fax Records ☐ Electronic Copy ☐ Call for pick-up ☐ Discuss verbally

3. INFORMATION TO BE RELEASED FROM YOUR RECORDS: Date of Service/ Content

☐ Office Visit _____ ☐ Medication history _____ ☐ Immunization _____
☐ Gyn visits_____ ☐ Lab work _____☐ Radiology report_____
☐ Billing _____ ☐ Entire record _____ ☐ 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 re-disclosure by the recipient(s). I understand that I have the right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that I have authorized the use and/or discourse of my health information and such use and /or disclosure has already occurred. I understand that I do not have the sign this authorization and that my refusal to sign will not affect my ability to obtain treatment form 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.

This authorization shall expire: __ in 6 months form the date I sign this authorization or
___other (describe) _____

4. SIGNATURE OF PATIENT: I certify that I have reviewed a copy of this authorization, understand the above statements and consent to the disclosure of my health records for the purpose and to the extent stated above.
5. 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: _____

➔ Signature _____ Today's date _____
Patient gave verbal permission _____
Signature of Witness _____ Date signed _____