WashU

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Washington University School of Medicine, Student Health Services, to transfer, release, or obtain information on:

(Name of Patient) _____ (Date of Birth) _____ (Student ID) _____

(Email) optional _____ (Phone) _____ Current Student: (Yes/No) _____

OBTAIN FROM:(DO NOT LEAVE BLANK)	DISCLOSE TO: (DO NOT LEAVE BLANK)
(Name/Physician/Provider/Institution)	(Physician/Provider/Institution/Parent/Guardian)
(Address)	(Address)
(City/State/Zip)	(City/State/Zip)
(Phone) (Fax)	(Phone) (Fax)

☐ **Check this box if you authorize Student Health Services to both release and obtain personal health information between the two parties listed above**

For the purpose of:

- ☐ Continuing Medical Care
- ☐ Legal purposes
- ☐ CAP Review
- ☐ Employment
- ☐ Academic Review and Support
- ☐ Patient Request
- ☐ Parent/Guardian Communication
- ☐ Study Abroad
- ☐ Collaboration with Other Campus Partners
- ☐ Other (specify): _____

☐ Mail Records ☐ Fax Records ☐ Discuss verbally ☐ Secure/Encrypted Email

☐ Email to Non-WUSTL email ☐ Call for Pick Up

By checking an email box, you are signifying that you understand that there is a risk that the requested information could be viewed by an unauthorized person when transmitted over the internet

Please Check Specific Information Requested

- ☐ Medical Health Record* **
- ☐ Radiology Images
- ☐ TB Test Results
- ☐ Physical Exam
- ☐ Radiology Reports
- ☐ Psychiatric/Psychological Records
- ☐ Office/Progress Notes
- ☐ Immunizations
- ☐ Medication Records
- ☐ Billing Statement(s)
- ☐ Health Status, Treatment updates (exclude sexual and mental health information) Recommended for family communications
- ☐ Other (specify): _____

If initialed below, I confirm that I request Washington University Student Health Services to specifically release the following records to the above agency or individual, and waive any privilege with respect to these specific records:

____ Initial for release of records of infectious or contagious diseases, (including HIV/AIDs confidential information)

____ Initial for release of health records including Psychiatry Evaluation and Notes

***Includes Medical Clinic visits to the Health Center, Labs, and Radiology - does NOT include Psychiatry Evaluation and Notes**

****** Does not include Center for Counseling and Psychological Services (CCPS) Notes**

• This request is 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 Student Health Services. I understand that the revocation will not apply to any information that has already been released in response to this authorization.

• I understand that I choose to not give this permission or if I can 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, I may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient(s).

• I understand that Student Health Services will respond to my request for health information within 30 days of receipt of my request. If my health information is not readily accessible to Student Health Services or is maintained in an off-site storage location, Student Health Services has an additional 30 days to respond to my request. If Student Health Services requires additional time to respond to my request, they will contact me to inform me of this extension of time.

Authorization is valid through the end of the academic calendar year (July 31 of the current academic year) OR as specified by selecting one of these options - a specific date (e.g. 1/1/25) or an event or special condition (e.g. graduation, marriage, change of therapist, etc.)

This authorization expires on the following date: _____

This authorization expires due to the following event or special condition: _____

_____ _____

Signature of Patient or Parent/Legal Representative **Date**