

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Provider Approval
Initials: _____
Date: _____

W _____
Student Number

_____ Patient Name

I REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED BY:

Student Health Center, WWU
516 High St., MS 9132
Bellingham, WA 98225
(360) 650-3400 FAX (360) 650-3883

INFORMATION TO BE RELEASED TO:

Phone (____) _____ Fax (____) _____

My initials and signature below authorize the release of health care information relating to testing, diagnosis, and treatment for:

PLEASE CHECK AND INITIAL ALL THAT APPLY BELOW

- _____ All clinic records (**Will not** include records received from other facilities. **Will not** include records from the categories listed below without your check mark and initials next to that category.)
- _____ ****Drug / Alcohol** diagnosis, treatment or referral information, including any drug or alcohol tests
- _____ ****Mental Health** Information
- _____ ****Sexually Transmitted Diseases** and/or Human Immunodeficiency Virus (H.I.V.) Antibody test results and related records
- _____ ****Pap smear and Sexually Transmitted Diseases** tests results and related records
- _____ ****Contraceptives and pregnancy** related records
- _____ Other: Specify _____

****This category of records MUST be checked and initialed to be included with the records to be released**

For care provided on: _____ (Provide the date or dates of treatment, if known)

The above information will be used for the following purpose(s):

- Billing insurance company or third party payer
- Information requested for legal process (i.e. subpoena or court order)
- Continuing medical care outside of WWU's Student Health Center
- Other: Specify _____

I expressly and voluntarily authorize disclosure of the above medical record(s) for the purpose(s) stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization. I understand that I do not have to sign this authorization in order to get health care benefit (treatment, payment, enrollment, or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that once this health information has been disclosed, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. This prohibition does not extend to insurance companies.

This authorization expires _____ (State date or event, required for release of records)

X _____
Signature of patient

DATE _____

Patient SSN _____ DOB _____ Other Names Used _____