

**AUTHORIZATION TO REQUEST 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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INFORMATION TO BE RELEASED TO:**

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

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

**Name of WWU Provider Needing the Records (if known):**  
\_\_\_\_\_

**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 at 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 \_\_\_\_\_