

## Authorization for the Use and Disclosure of Protected Health Information

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORMATION TO BE RELEASED FROM THE HEALTH RECORD OF:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Email Address \_\_\_\_\_ Student ID# \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

2. RELEASE RECORDS  FROM or  TO (check one)



RELEASE RECORDS  FROM or  TO (check one)

Student Health Services  
 One Brookings Drive-Campus Box 1201  
 Saint Louis, MO 63130-4862  
 Phone: 314-935-6666 Fax: 314-935-8515 Website: shs.wustl.edu

Name/Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Phone \_\_\_\_/\_\_\_\_/\_\_\_\_ Fax \_\_\_\_/\_\_\_\_/\_\_\_\_

- Mail records
- Fax Records
- Call for pick-up
- Discuss verbally

▶ A fee may be associated with your request for release of records

3. INFORMATION TO BE RELEASED FROM YOUR GENERAL MEDICAL RECORD:

Date of Service/Content	Date of Service/ Content
<input type="checkbox"/> Office visit _____	<input type="checkbox"/> Radiology report _____
<input type="checkbox"/> GYN visits _____	<input type="checkbox"/> Xray _____
<input type="checkbox"/> Lab Work _____	<input type="checkbox"/> Billing receipts _____
<input type="checkbox"/> Immunizations _____	<input type="checkbox"/> Entire Record _____
<input type="checkbox"/> Physical Therapy Notes _____	<input type="checkbox"/> Other _____

▶ If specific date(s) are not indicated, all records in the category marked will be released.

4. INFORMATION TO BE RELEASED FROM YOUR  COUNSELING AND/OR  PSYCHIATRIC RECORD:

Date of Service/Content	Date of Service/Content
<input type="checkbox"/> Office visit _____	<input type="checkbox"/> Drug/Alcohol Issues _____
<input type="checkbox"/> Medication history _____	<input type="checkbox"/> Entire Record _____
<input type="checkbox"/> Assessment _____	<input type="checkbox"/> Attendance _____
<input type="checkbox"/> Treatment Plan _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Progress Notes _____	

5. INFORMATION IS TO BE USED FOR:

- Academic Considerations
- Contact with Referral Source
- Continuity of Treatment
- Family Involvement
- Collaboration with other campus organizations
- 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 redisclosure by the recipient(s). I understand that I have the right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my health information and such use and/or disclosure has already occurred. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from 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 as is explained in the Notice of Privacy Practices.

This authorization shall expire: \_\_\_\_ in 6 months from the date I sign this authorization; or  
 \_\_\_\_ Other (describe) \_\_\_\_\_

6. SIGNATURE OF PATIENT/CLIENT: I certify that I have reviewed a copy of this authorization, understand the above statements, and consent to the disclosure of my health record for the purpose and to the extent stated above.

▶ Signature \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Name of Personal Representative \_\_\_\_\_ Relationship to Individual \_\_\_\_\_

Individual Unable to sign due to: \_\_\_\_\_ Patient/Client gave verbal permission.

Signature of Witness \_\_\_\_\_ Date Signed \_\_\_\_\_

**To Be Completed by Washington University**

**Method of Identity Verification:**

**For Individual:**

\_\_\_ Individual known to Washington University

\_\_\_ Picture ID of individual

\_\_\_ Match of individual signature with Washington University documents

**For Requesting Party other than Individual: (Both required)**

\_\_\_ Picture ID of requesting party

\_\_\_ Signed letter of authorization or completion of this form by individual

**Signature of Washington University Staff Member Verifying Identity:** \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_