

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. INFORMATION TO BE RELEASED FROM YOUR GENERAL MEDICAL RECORD:

Office visit, GYN visits, Lab Work, Immunizations, Physical Therapy Notes, Radiology report, Xray, Billing receipts, Entire Record, Other

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

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

Office visit, Medication history, Assessment, Treatment Plan, Progress Notes, Drug/Alcohol Issues, Entire Record, Attendance, Other

4. IS TO BE USED FOR

Academic Considerations, Contact with Referral Source, Continuity of Treatment, Family Involvement, Collaboration with other campus organizations, Other

In what format would you like to receive your records: Paper Copy, Electronic Copy, Fax

Release or Mail To:

Individual/Legal Guardian/Personal Representative, Street Address, City, State and Zip Code, Phone Number of Individual Receiving Records if not Patient, Email Address

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:

Processing Your Requested Information:

Washington University Physicians may charge a fee for the copying of requested health information plus postage for mailing the copies to you.

Washington University Physicians will respond to your request for health information within 30 days of our receipt of your request. If, however, your health information is not readily accessible by Washington University Physicians or is maintained in an off-site storage location, Washington University Physicians has an additional 30 days to respond to your request. If we require additional time to respond to your request, we will contact you to inform you of this extension of time.

We appreciate your patience while we process your request.

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

Signature of Patient/Legal Guardian/Personal Representative Date: _____

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: _____