Records Release TO Student Health: Student Health Services
One Bookings Drive, CB 1201
St. Louis, MO 63130-4862
Phone: (314) 935-6666
Fax: (314) 935-8515
Website: shs.wustl.edu

Authorization for the Use and Disclosure of Protected Health Information

1. I AUTHORIZE THE FOLLOWING PROTECTED HEALTH INFORATION 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:

	Date of Service/Content		Date of Service/ Content
☐ Office visit	______________________	☐ Radiology report	______________________
☐ GYN visits	______________________	☐ Xray	______________________
☐ Lab Work	______________________	☐ Billing receipts	______________________
☐ Immunizations	______________________	☐ Entire Record	______________________
☐ Physical Therapy Notes	______________________	☐ 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:

	Date of Service/Content		Date of Service/Content
☐ Office visit	______________________	☐ Drug/Alcohol Issues	______________________
☐ Medication history	______________________	☐ Entire Record	______________________
☐ Assessment	______________________	☐ Attendance	______________________
☐ Treatment Plan	______________________	☐ Other	______________________
☐ Progress Notes	______________________		______________________

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

Released or Mailed From:

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 <u>not</u> <u>encrypt</u> 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) ____

____ Date:______________
Signature of Patient/Legal Guardian/Personal Representative

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: ______________________________________