Washington University in St.Louis

# Authorization for the Use and Disclosure of Protected Health Information

**The undersigned authorizes Washington University Student Health Services to:**

**____ Release or ____ Obtain:**

☐ **Written Copy or**
☐ **For Verbal Conference**

_______________________________ _______________________
*Name* *Relationship to Student*

_______________________________ _______________________
*Address* *Phone Number*

_______________________________ _______________________
*City/State/Zip* *Fax Number*

**The following information:**

- ___Assessment
- ___Treatment Plan
- ___Progress Notes
- ___Discharge Summary
- ___Psychological Testing
- ___Drug/Alcohol Issues
- ___All of the Above
- ___Other:_____________________________________________

**The 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 (HIPPA). 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) ___________________________________________**

***I certify that I have reviewed a copy of this authorization.***

_______________________________ _______________________ _______________
***Signature*** ***Phone #*** ***Date***
***Student ID#***______________________ ***BD:***________________

_______________________________
***Printed Name***

_______________________________ _______________________
*Name of Personal Representative* *Relationship to Individual*

Individual unable to sign due to:___________________________________. Individual gave verbal permission.

_______________________________ _______________________
***Signature of Witness*** ***Date***

**Washington University in St. Louis, One Brookings Drive, Campus Box 1201, St. Louis, MO 63130-4862**
**Fax: 314-935-5781** **PH: 314-935-6666** **website: shs.wustl.edu**

**(OVER)**

## 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: ______________________________________

(Revised 8 05)