AUTHORIZATION TO RELEASE MEDICAL INFORMATION

W _____ _____ _____ _____

Student Number | Patient Name | Date of Birth | Other Names Used

I REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED BY:

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

INFORMATION TO BE RELEASED TO:

(Must include name, office or clinic name and address or fax)

_____

_____

_____

_____

Phone (____)_____ Fax (____)_____

My initials and signature below authorize the release of health care information relating to testing, diagnosis, and treatment for:

PLEASE INITIAL ALL THAT APPLY BELOW

_____ All clinic records

OR _____ Release records for care provided on or during the period of _____

OR _____ Release records for this condition (specify) _____

Records in the following categories MUST be initialed to be released:

_____ Sexually transmitted diseases, antibody test results and related records, including pap smear results

_____ Contraceptives and pregnancy related records

_____ Acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV)

_____ Behavioral or mental health services

_____ Drug / Alcohol diagnosis, treatment or referral information, including any drug or alcohol tests

_____ Other: Specify _____

_____ Do not release records from other facilities or providers outside WWU Student Health Center

_____ Do not release records from _____ (date) as I paid for services on this date out-of-pocket

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 outside of 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 or per WWU Notice of Privacy Practices. 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 (required for release of records):

☐ 90 days from the dated signed ☐ On (date):_____ ☐ When the following event occurs: _____

(If left blank, this release will expire in 90 days from the date signed)

X _____ **DATE** _____

Signature of patient

Created 4/8/03, Rev 7/16/03, 10/06, 9/23/13