

AUTHORIZATION TO REQUEST 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:

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

Phone (____) _____ Fax (____) _____

INFORMATION TO BE RELEASED TO:

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

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 _____

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 at 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 _____
Signature of patient

DATE _____