



Student Health Center

516 High Street, MS 9132

Bellingham, WA 98225

Ph: 360.650.3400 Fax: 360.650.3883

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this form.

Patient Name: _____

Date of Birth: _____

Student W#: _____

Contact Ph#: _____

Address: _____

City/State/Zip: _____

1. Information to be Released By

Western Washington University Student Health Center

Physician/Other: _____

Address: _____

Phone: _____ Fax: _____

2. Information to be Released To

Patient (Self)

Western Washington University Student Health Center (see address/fax# above)

Physician/Other: _____

Address: _____

Phone: _____ Fax: _____

3. Information to be Disclosed

My initials and signature authorize Western Washington University's Student Health Center or the above named person/entity to disclose my protected health information as indicated below.

PLEASE INITIAL NEXT TO ALL THAT APPLY:

_____ Treatment notes on or during the period of: _____

_____ Records related to this condition (specify): _____

_____ Lab/test results (specify): _____

_____ Other: _____

If you want the above types of records to be restricted to a specific period of time, please indicate dates below. Only release the specific types of records initialed above created during the time period of:

_____ To _____

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

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

_____ Reproductive health related records

_____ HIV/AIDS related records

_____ Behavioral or mental health services

_____ Drug/alcohol related records

_____ Other (specify): _____

4. Purpose of Release of information

The purpose of releasing the records to the above named party(ies) is:

PLEASE INITIAL NEXT TO ALL THAT APPLY:

_____ At the request of the patient

_____ Continued treatment or monitoring outside WWU's Student Health Center

_____ Academic support services

_____ Billing or third party payer

_____ Legal

_____ Other: _____

5. Expiration of Authorization

This authorization will automatically expire 90 days from the date signed unless a different date is requested below:

Client's preferred date authorization is to expire if less than 90 days: _____

Note: If the disclosure is to an employer or financial institution, state law prohibits the expiration date from being longer than 1 year after this authorization is signed.

You may revoke this authorization at any time prior to the 90 days, or the printed expiration date, by notifying the SHC by providing a written request electronically, by mail, in person, or by fax. This authorization will cease to be effective on the date the revocation is received except to the extent action has already been taken in reliance upon it, or per any exception noted in the SHC's Notice of Privacy Practices.

6. Patient Authorization

- 1) I expressly and voluntarily authorize disclosure of the record(s) in Section 2 for the purpose stated in Section 3.
- 2) I understand that once these records are released pursuant to this authorization, the recipient may not be obligated by federal or state law to protect them. The SHC has no control over re-disclosure.
- 3) I understand that the SHC will not condition treatment, payment, enrollment or eligibility for benefits on this authorization, except when the sole purpose of the healthcare is to create health information for a third party.

Patient/Personal Representative Signature

Date

Personal Representative Name (PRINT)

Relationship to Patient

Note: A personal representative may be required to provide appropriate documentation to demonstrate authority to act on behalf of the patient.

7. Recipient Limitations on Use of Records Disclosed

Student educational records, including health records, receive additional protections under the Family Educational Rights and Privacy Act. The person and/or entity receiving this information is not authorized to re-disclose the information received as a result of this disclosure unless specifically authorized in writing by the patient or by law.