AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION

Student Health Center
516 High Street, MS 9132
Bellingham, WA 98225
Ph: 360.650.3400 Fax: 360.650.3883
student.health@wwu.edu

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.

Please Fax, Email, or Mail signed and completed request to address at the top of this form