

STUDENT HEALTH AND COUNSELING CENTER

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____
Student ID # _____ Previous Name (If Applicable): _____
Mailing Address: _____
City _____ State _____ Zip Code _____
Phone: _____

I hereby request and authorize the information to be released / received / released and received (circle one):

Organization: _____
Address: _____
City _____ State _____ Zip Code _____
Phone _____ FAX _____

I hereby request and authorize information to be released / received / released and received (circle one):

The Evergreen State College Student Health and Counseling Center
2700 Evergreen Parkway NW; Seminar I
Olympia, WA 98505

HEALTH: Phone: 360-867-6200 **FAX: 360-867-6787** **COUNSELING:** Phone: 360-867-6800 **FAX: 360-867-5441**

INFORMATION TO BE RELEASED / RECEIVED: All Date(s) or date range: _____

My health information relating the following condition or treatment: _____

Billing Information Other: _____

I give my specific authorization for these records to be released / received in: (please initial all that apply)

_____ Written format _____ Verbally

INCLUDE the following information from my records (please initial):

I understand that my records may contain information regarding the following sensitive diagnosis or treatment. I give my specific authorization for these records to be released / received: (please initial all that apply).

_____ Drug/Alcohol abuse diagnosis/treatment _____ Sexually Transmitted Diseases
_____ HIV/AIDS testing/diagnosis/treatment _____ Mental Illness/Psychiatric diagnosis/treatment

PURPOSE FOR DISCLOSURE:

Patient's Request Continuing Care Legal Insurance Transfer of Care
 Coordination of Care Other (explain): _____

This Release expires on September 30, 2012.

Note: An expiration date is not required if the recipient of the records is the patient or the patient's personal representative.

MY RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form in order to take part in a research study OR to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by TESC Student Health and Counseling Center based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The way to revoke this authorization is to write a letter to: TESC Student Health and Counseling Center; Attn: Medical Records; 2700 Evergreen Parkway NW; Seminar I 2110; Olympia, WA 98505

Once TESC Student Health Center discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Signature of Patient/Client: _____ **Date:** ____/____/____

Signature of Witness: _____ **Date:** ____/____/____