Student Wellness Services

Authorization to Release Protected Health Information

Legal Name ______________________________ **Previous Name** ____________________
Last *First* *MI* *(if applicable)*

Student A# ____________________ **DOB** _____/_____/_____ **Phone** ____________________
Evergreen ID *Month* *Day* *Year*

Mailing Address ____ __________
Street *Unit*

____ __________
City, State, Zip

Information To Be Released FROM:

☐Provider/Clinic: ____________________
Address ____________________
____
City __________ State ______ Zip______
Phone __________ Fax __________

OR

☐The Evergreen State College
Student Wellness Services
2700 Evergreen Parkway NW, Seminar 1 – 2110
Olympia, WA 98505

Phone: 360-867-6200 **Fax: 360-867-6787**

Information To Be Released TO:

☐The Evergreen State College
Student Wellness Services
2700 Evergreen Parkway NW, Seminar 1 – 2110
Olympia, WA 98505

Phone: 360-867-6200 **Fax: 360-867-6787**

OR

☐Provider/Clinic: ____________________
Address ____________________
____
City __________ State ______ Zip ______
Phone __________ Fax __________

Type of information (check all that apply):

☐ All Records
☐ All (circle) medical / mental health records from date __________ to date __________
☐ Specific condition or treatment ______________________________
☐ Billing information ______________________________
☐ Other (describe) ______________________________
☐ I authorize verbal communication about my medical and/or mental health history and care.

Patient Authorization - Initials REQUIRED:
I understand that my records may contain information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness, or psychiatric condition. I give my special authorization for this information to be released.

INITIALS: __________

This Release expires on September 30, 2021.
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 Wellness Services 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 Wellness Services; Attn: Medical Records; 2700 Evergreen Parkway NW; Seminar I 2110; Olympia, WA 98505.
Once TESC Student Wellness Services 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:** _____/_____/_____