# 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, 2022.**
***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:**_____/_____/_____