

# Student Wellness Services

## Authorization to Release Protected Health Information

<b>Legal Name</b> _____	<b>Previous Name</b> _____	
<small>Last</small>	<small>First MI (if applicable)</small>	
<b>Student A #</b> _____	<b>DOB</b> ____/____/____	<b>Phone</b> _____
	<small>Month Day Year</small>	
<b>Mailing Address</b> _____		
<small>Street</small>	<small>Apt#</small>	
<small>City, State, Zip</small>		

**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 I  
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 I  
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, 2019.**

**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:** \_\_\_\_/\_\_\_\_/\_\_\_\_