

Student Wellness Services

Authorization to Release Protected Health Information

Legal Name _____	Previous Name _____	
<small>Last</small>	<small>First MI (if applicable)</small>	
Student A # _____	DOB _____ / _____ / _____	Phone _____
	<small>Month Day Year</small>	
Mailing Address _____		
<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, 2020.
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:** _____ / _____ / _____