



Authorization for Use or Disclosure of Protected Health Information

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
919#: \_\_\_\_\_ SS# \_\_\_\_\_
Address (Street, City, State, Zip): \_\_\_\_\_
Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

University Wellness Services

Clinic Services

Counseling Services

Prevention, Outreach, and Education

660.562.1348 office

660.562.1585 fax

I hereby authorize: To obtain and/or release protected health information as indicated below to/from the following agency/individual:

Wellness Services Name: \_\_\_\_\_
800 University Drive Address: \_\_\_\_\_
Maryville, MO 64468 City/State/Zip: \_\_\_\_\_
Phone: (660) 562-1348 Phone: \_\_\_\_\_
Fax: (660) 562-1585 Fax: \_\_\_\_\_

- I give permission for Wellness Services to VERBALLY discuss protected health information, as identified below, with this agency/individual on the basis that they are a caregiver or personal representative that is involved in my health care, care coordination, or payment of my health care.

Information to be released, from dates: \_\_\_\_\_ to \_\_\_\_\_

- All Records / Protected Health Information (includes all categories below) (Initial here): \_\_\_\_\_
Scheduling/Appointment, Billing, and Payment Information
Partial Records (specify below)
GYN Records
Pathology/Lab Reports (specify below)
Radiology/X-Rays (specify below)
Mental Health Records (Initial here): \_\_\_\_\_
Psychiatric Records (Initial here): \_\_\_\_\_
HIV/AIDS, STI Testing (Initial here): \_\_\_\_\_

Comments: \_\_\_\_\_

Purpose of Disclosure:

- Changing Physicians Continuing Care Consultation
Legal At my (student's) request Second Opinion
Other: \_\_\_\_\_

I understand that this authorization is valid for one (1) calendar year after the date of my signature. I may revoke this authorization at any time by notifying University Wellness Services in writing, and this authorization will cease to be effective on the date notified (except to the extent action has already been taken in reliance upon it).

800 University Drive
Maryville, MO 64468-6001
www.nwmissouri.edu/wellness

Student Signature: \_\_\_\_\_ Received By: \_\_\_\_\_
Date: \_\_\_\_\_ Date: \_\_\_\_\_

Or:

Parent/Guardian Signature: \_\_\_\_\_
Date: \_\_\_\_\_