University Wellness Services

Clinic Services

Counseling Services

Prevention, Outreach, and Education

660.562.1348 office

660.562.1585 fax

Authorization for Use or Disclosure of Protected Health Information

Student Name:____Date of Birth:__________________
919#:____SS#_________________________________
Address (Street, City, State, Zip):____
Phone: (_____) __________________ Cell: (_____) ___________________

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). I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. I understand that my refusal to sign this authorization will not jeopardize my right to obtain treatment, and my health care (and payment for my health care) will not be affected. By signing below, I acknowledge that I have read and understand this authorization.

Student Signature:_____________________________________ Received By:________________
Date:____ Date:_______________________

Or:

Parent/Guardian Signature:____
Date:____

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

Document Date: September 2019