AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Center for Student Wellness, Division of Student Affairs, Winthrop University

1. Regarding Patient COMPLETE IN FULL

Name - Last, First, MI	Birthdate	WID #
Telephone #	Duration of Release, not to exceed 365 days: From ___/___/___ To ___/___/___	

2. Records Released TO

Name - (i.e. Health Facility, Provider...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

3. Records Released FROM

Name - (i.e. Health Facility, Provider...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

4. REASON FOR DISCLOSURE:
☐ Treatment Planning/Coordination with other Professionals ☐ Legal Inquiry ☐ Assessment
☐ Insurance Verification ☐ School Disability ☐ Medical Withdrawal
☐ Consultation with Referral Source ☐ Consultation with Faculty/Staff ☐ Other: ____

5. MEDICAL INFORMATION TO BE RELEASED (if applicable):
Date(s) of treatment/visit: __________________________________
☐ Medical History, Exam, Physical ☐ X-Ray Reports ☐ Prescriptions ☐ Hospital Reports
☐ Allergy Records ☐ Laboratory Reports ☐ Immunizations ☐ Pap Results
☐ Surgical Reports ☐ Entire Record ☐ Telephone/verbal communication ☐ Itemization/Coding
☐ Counseling & Consultation Visits (not Counseling Services) ☐ Other: ____

6. COUNSELING /PSYCHOLOGICAL INFORMATION TO BE RELEASED (if applicable):
Date(s) of treatment/visit: __________________________________
☐ Diagnosis and Prognosis ☐ Attendance/Contact Record ☐ Progress Status ☐ Treatment Suggestions
☐ Consultations ☐ Psychiatric Notes ☐ Intake Summary ☐ Discharge Summary
☐ Assessments/Evaluations ☐ Information about disability and accommodations
☐ Other ____

7. DISABILITY SERVICES INFORMATION TO BE RELEASED (if applicable):
Date(s) registered with Services for Students with Disabilities: __________________________________
☐ Copies of Disability Documentation ☐ Information about Accommodations
☐ Other ____

8. PRIVILEGED INFORMATION TO BE RELEASED (if applicable):
Date(s) of treatment/visit: __________________________________
☐ STI ☐ Developmental Disability ☐ HIV/AIDS ☐ Drug Abuse
☐ Alcohol Abuse ☐ Other: ____

9. PATIENT RIGHTS:
I have had the opportunity to read this facility's Notice of Privacy Practices (as indicated) and have had all of my questions regarding this Notice answered to my satisfaction. I understand that only health care providers, plans, and clearinghouses must follow the federal privacy standards. If an individual or organization receiving my protected health information (PHI) does not fall into one of these categories, this authorization ceases to be protected by the federal privacy standards therefore, allowing for the possibility of my PHI being redisclosed without further authorization. I understand that I may cancel this authorization but that my withdrawal is only effective to the extent that action has not already been taken, as a result of my signing this form. In order to withdraw this authorization written notification is required.

This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

____ ____
Patient/Client/Student Signature Date