AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

West Chester University
Student Health Services
West Chester, PA 19383
610-436-2509 (Phone)
610-436-3148 (Fax)

I understand that my medical record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health/rehabilitation, HIV/AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information NOT be disclosed by initialing below.

____ Alcohol/Drug Abuse and/or Dependence ____Mental Health/Rehabilitation ____ HIV/ AIDS ____ Sexual Assault

_____ _____ _____
Last Name First Name WCU ID # Date of Birth

_____
Address

_____
City/State/Zip

I authorize the Student Health and Wellness Center to DISCLOSE/VERBALLY DISCLOSE/RECEIVE Protected Health Information contained in my medical record TO/FROM:

Name/Organization_____

Address_____

City/State/Zip_____

Phone ( ) _____ Fax ( ) _____

Information to be disclosed (one or more boxed must be checked and dates must be specific):

☐Immunizations ☐Treatment Notes ☐Lab Reports ☐Radiology Reports

☐Other: _____

The information released shall include documentation from my medical record from _____ through _____
Date **Date**

Reason for which I am authorizing disclosure:

☐Continuation of Care ☐Payment of a Claim ☐Personal Use ☐Other:

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Student Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization expires _____. If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I also understand that the information disclosed according to this release may be re-disclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

_____ _____ _____
Signature of patient or legal representative Date If signed by legal representative, relationship to patient

Office Use Only: Date Received _____ Person Assisting with form Completion_____
Release Method: ☐ Mail ☐Fax ☐Hand Carry (date) _____