WashU Cares Student Support
One Brookings Drive: MSC 1201-323-10
Washington University in St. Louis
St Louis, MO 63130 - 4899

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize WashU Cares Student Support to transfer, release, or obtain information on:

_____ _____ _____
(Name of Patient) **(Date of Birth)** **(Student ID)**

_____ _____ _____
(Email) optional **(Phone)** **Current Student: (Yes/No on leave)**

OBTAIN FROM: (DO NOT LEAVE BLANK)	**DISCLOSE TO: (DO NOT LEAVE BLANK)**
_____ (Name/Physician/Provider/Institution)	**__Wash U MLOA Committee __** (Name/Physician/Provider/Institution)
_____ (Address)	_____ (Address)
_____ (City/State/Zip)	_____ (City/State/Zip)
_____ _____ (Phone) (Fax)	**__314-935-5956__** **__ 314-970-9093__** (Phone) (Fax)

☐ Check this box if you authorize WashU Cares to both release and obtain personal health information between the two parties listed above, **for the purpose of (check all that apply):**

☐Continuation of Care
☐Legal Purposes
☐Employment
☐Academic Support
☐Depart/Return to Campus
☐Parent/Guardian Communication
☐ Study Abroad
☐Collaboration with Other Campus Partners
☐ Patient Request
☐ Other_____

Check all that apply:
☐Fax Records ☐Discuss Verbally ☐Secure/Encrypted Email ☐E-mail to non-WUSTL email (***By checking email box, you understand that there is a risk that the requested information could be viewed by an unauthorized person when transmitted over the internet)***

Please Check Specific Counseling Information Requested
☐Medical Health Records ☐Counseling Records ☐Psychiatry Notes ☐Treatment Plan ☐Discharge Notes ☐Treatment Notes for Alcohol/Other Drug Use/Abuse ☐Other (specify) _____ ____Initial for release of records of drug or alcohol use/abuse or treatment of same.

This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time by sending a written notice of revocation to Center for Counseling and Psychological Services. I understand that the revocation will not apply to any information that has already been released in response to this authorization.

• I understand that if I choose to not give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

• I understand that once my information is used and/or disclosed pursuant to this authorization, it may no longer be protected by federal privacy regulations and may be subject to re-disclosure by the recipient(s).

• I understand that a reasonable fee may be charged unless copies are sent to another clinician or healthcare facility. This fee is based on the cost of the labor and supplies involved in copying the requested health information. Copies sent to other recipients (i.e. attorney, insurance companies) are subject to fees as provided by state law.

Authorization is valid through the end of the academic calendar year (July 31) (if not otherwise specified) OR as specified by selecting one of these options (for example: graduation/year):

☐This authorization expires on the following date _____.
☐This authorization expires due to the following event or special condition
_____ .

_____ _____
Signature of Patient or Parent/Legal Represent Date