NORTHWEST
MISSOURI STATE UNIVERSITY

University
Wellness Center

660.562.1348 office
660.562.1857 fax

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

919 # _____ SS# _____

Address: _____

Phone Number: _____Cell Number: _____

I hereby request and authorize Northwest Missouri State University Wellness Center to disclose my protected health information as indicated below TO:

Dr/Clinic Name: _____

Clinic Address: _____

Phone Number: _____

Fax Number: _____

☐To student named above

_____ Partial records (please specify) _____

_____ GYN records

_____ All records

_____ Lab reports/X-rays (please specify) _____

_____ Pathology reports (please specify) _____

_____ Mental health records (**please sign**) _____

_____ HIV/AIDS, other STD testing (**please sign**) _____

Purpose of disclosure:

☐Changing physicians ☐Consultation ☐Legal ☐For personal access

☐Other (please specify)_____

I understand that authorization is valid for 180 days after the date of my signature and may be revoked at any time in writing prior to the expiration date.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Date received: _____ Date sent: _____ Mailed: _____

Faxed: _____ Picked up: _____ Initials: _____

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