NORTHWEST
MISSOURI STATE UNIVERSITY

University Wellness Services

Clinic Services

Personal Development and Counseling Services

Prevention, Outreach, and Education

660.562.1348 office

660.562.1585 fax

Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____
919#:_____ SS#_____
Address (Street, City, State, Zip):_____
Phone: (_____) _____ Cell: (_____) _____

I hereby authorize:

□ University Wellness Services
800 University Drive
Maryville, MO 64468
Phone: (660) 562-1348
Fax: (660) 562-1585

□ Name:_____
Address:_____
City/State/Zip:_____
Phone:_____
Fax:_____

To use or disclose my protected health information as indicated below to:

□ University Wellness Services
800 University Drive
Maryville, MO 64468
Phone: (660) 562-1348
Fax: (660) 562-1585

□ Name:_____
Address:_____
City/State/Zip:_____
Phone:_____
Fax:_____

Information to be released, from dates: _____ to:_____

□ All Records
□ Partial Records (specify below)
□ Pathology/Lab Reports (specify below)
□ Radiology/X-Rays (specify below)
□ GYN Records
□ Mental Health Records (sign here): _____
□ HIV/AIDS, STD Testing (sign here):_____

Comments:_____
_____

Purpose of Disclosure:
□ Changing Physicians
□ Continuing Care
□ Consultation
□ Legal
□ At my (patient'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.

Patient Signature:_____ Received By:_____
Date:_____ Date:_____

Or:

Parent/Guardian Signature:_____
Date:_____

For Office Use Only

Date Received:_____ Date Sent:_____ Mailed:_____
Faxed:_____ Picked Up:_____ Initials:_____

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