NORTHWEST
MISSOURI STATE UNIVERSITY

University Wellness Services

Clinic Services

Counseling Services

Prevention, Outreach, and Education

660.562.1348 office

660.562.1585 fax

Authorization for Use or Disclosure of Protected Health Information

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

I hereby authorize:

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

To ***obtain and/or release*** protected health information as indicated below to/from the following agency/individual:

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

☐ I give permission for Wellness Services to VERBALLY discuss protected health information, as identified below, with this agency/individual on the basis that they are a caregiver or personal representative that is involved in my health care, care coordination, or payment of my health care.

Information to be released, from dates: _____ to _____

□ All Records / Protected Health Information (includes all categories below) (Initial here): _____
□ Scheduling/Appointment, Billing, and Payment Information
□ Partial Records (specify below)
□ GYN Records
□ Pathology/Lab Reports (specify below)
□ Radiology/X-Rays (specify below)
□ Mental Health Records (Initial here):_____
□ Psychiatric Records (Initial here):_____
□ HIV/AIDS, STI Testing (Initial here):_____

Comments:_____
_____

Purpose of Disclosure:

□ Changing Physicians □ Continuing Care □ Consultation
□ Legal □ At my (student'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.

Student Signature:_____ Received By:_____
Date:_____ Date:_____

Or:

Parent/Guardian Signature:_____
Date:_____

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

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