



Authorization for Use or Disclosure of Protected Health Information

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

University Wellness Services

Clinic Services

Counseling Services

Prevention, Outreach, and Education

660.562.1348 office

660.562.1585 fax

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

Wellness Services Name: _____
800 University Drive Address: _____
Maryville, MO 64468 City/State/Zip: _____
Phone: (660) 562-1348 Phone: _____
Fax: (660) 562-1585 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

Date(s) of Services: From: ____/____/____ To: ____/____/____.

- All Records (____) Initial here* (Protected Health Information that includes all partial record categories)

- Partial Records
Billing / Payment / Appointment (s)
GYN Records (____) Initial here*
HIV / AIDS / STI Screening (____) Initial here*
Pathology / Lab Results
Specify: _____
Radiology / X-Rays
Specify: _____
Mental Health Records (____) Initial here*
Psychiatric Records (____) Initial here*
Vaccinations / Immunizations
Other
Specify: _____

*Failure to initial, where indicated, will delay the release of your records.

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).

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

Student Signature: _____
Date: _____