WASHINGTON STATE UNIVERSITY

Authorization to Send Health Information

HEALTH & WELLNESS SERVICES
PO Box 642302 ● Pullman, WA 99164-2302
509-335-3575 ● Fax 509-335-6223

PATIENT NAME *(last, first, middle)*			FORMER NAME	
CURRENT ADDRESS	CITY		STATE	ZIP
TELEPHONE	WSU ID #		DATE OF BIRTH	

I authorize WSU HWS to send my records to:

INDIVIDUAL, CLINIC OR PROVIDER TO WHOM RECORDS ARE TO BE SENT:	PHONE#
ADDRESS	FAX #
CITY, STATE, ZIP	

OR **HOLD FOR ME TO PICK UP AT THE RECEPTION DESK** ☐

You may use or disclose the following health care information *(check all that apply)***:**

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other, please specify: _____
- ☐ Discuss my records with: _____

I understand that this release will become effective on the day I sign it. This authorization ends:

- ☐ on *(date)*:_____ ☐ when the following event occurs: _____
- ☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

I may cancel this release at any time by notifying the *record holder* in writing. I release the clinic/provider and its staff from all legal responsibility that may arise from this release of information. A copy of the Health and Wellness Services Privacy Notice has been offered to me. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

SIGNATURE	DATE

Specific Consent for Release of Sensitive Medical Information

You may use or disclose health care information regarding testing, diagnosis, and treatment for *(check all that apply)***:**

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

Signature:_____ Date: _____

FOR OFFICE USE ONLY:

_____ Copy mailed
_____ Copy faxed
_____ Copy given to patient
_____ Copy held for pick up

Comments: _____

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Authorization to Receive Health Information

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PO Box 642302 ● Pullman, WA 99164-2302
509-335-3575 ● Fax 509-335-6223

PATIENT NAME *(last, first, middle)*		FORMER NAME	
CURRENT ADDRESS	CITY	STATE	ZIP
TELEPHONE	WSU ID #	DATE OF BIRTH	

I authorize the following individual, clinic or provider to send my records to WSU HWS:

CLINIC/HEALTH CARE PROVIDER NAME	PHONE #
ADDRESS	FAX #
CITY, STATE, ZIP	

You may use or disclose the following health care information *(check all that apply)***:**

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other, please specify: _____
- ☐ Discuss my records with: _____ _____
- ☐ ADD/ADHD testing and/or Psychologist/Psychiatrist assessment of ADD/ADHD: _____

I understand that this release will become effective on the day I sign it. This authorization ends:

- ☐ on *(date)*:_____ ☐ when the following event occurs: _____
- ☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

I may cancel this release at any time by notifying the *record holder* in writing. I release the clinic/provider and its staff from all legal responsibility that may arise from this release of information. A copy of Health and Wellness Services Privacy Notice has been offered to me (see reverse side of this form). Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

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