

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Health and Counseling Services, Division of Student Affairs, Winthrop University

1. Regarding Patient COMPLETE IN FULL

Name - Last, First, MI	Birthdate	WID #
Telephone #	Duration of Release, not to exceed 365 days: From ___/___/___ To ___/___/___	

2. Records Released TO

Name - (i.e. Health Facility, Provider...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

3. Records Released FROM

Name - (i.e. Health Facility, Provider...)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

4. REASON FOR DISCLOSURE:

- | | | |
|---|--|---|
| <input type="checkbox"/> Treatment Planning/Coordination with other Professionals | <input type="checkbox"/> Legal Inquiry | <input type="checkbox"/> Assessment |
| <input type="checkbox"/> Insurance Verification | <input type="checkbox"/> School Disability | <input type="checkbox"/> Medical Withdrawal |
| <input type="checkbox"/> Consultation with Referral Source | <input type="checkbox"/> Consultation with Faculty/Staff | <input type="checkbox"/> Other: _____ |

5. MEDICAL INFORMATION TO BE RELEASED (if applicable):

Date(s) of treatment/visit: _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Medical History, Exam, Physical | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Hospital Reports |
| <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Pap Results |
| <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Entire Record | <input type="checkbox"/> Telephone/verbal communication | <input type="checkbox"/> Itemization/Coding |
| <input type="checkbox"/> Counseling & Consultation Visits (not Counseling Services) | <input type="checkbox"/> Other: _____ | | |

6. COUNSELING /PSYCHOLOGICAL INFORMATION TO BE RELEASED (if applicable):

Date(s) of treatment/visit: _____

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Diagnosis and Prognosis | <input type="checkbox"/> Attendance/Contact Record | <input type="checkbox"/> Progress Status | <input type="checkbox"/> Treatment Suggestions |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Psychiatric Notes | <input type="checkbox"/> Intake Summary | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Assessments/Evaluations | <input type="checkbox"/> Information about disability and accommodations | | |
| <input type="checkbox"/> Other: _____ | | | |

7. DISABILITY SERVICES INFORMATION TO BE RELEASED (if applicable):

Date(s) registered with Services for Students with Disabilities: _____

- | | |
|---|---|
| <input type="checkbox"/> Copies of Disability Documentation | <input type="checkbox"/> Information about Accommodations |
| <input type="checkbox"/> Other: _____ | |

8. PRIVILEGED INFORMATION TO BE RELEASED (if applicable):

Date(s) of treatment/visit: _____

- | | | | |
|--|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> STI | <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Other: _____ | | |

9. PATIENT RIGHTS:

I have had the opportunity to read this facility's Notice of Privacy Practices (as indicated) and have had all of my questions regarding this Notice answered to my satisfaction. I understand that only health care providers, plans, and clearinghouses must follow the federal privacy standards. If an individual or organization receiving my protected health information (PHI) does not fall into one of these categories, this authorization ceases to be protected by the federal privacy standards therefore, allowing for the possibility of my PHI being redisclosed without further authorization. I understand that I may cancel this authorization but that my withdrawal is only effective to the extent that action has not already been taken, as a result of my signing this form. In order to withdraw this authorization written notification is required.

This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Patient/Client/Student Signature

Date