Authorization to Disclose Health Care Information

Seattle University Student Health Center
1111 E. Columbia Street #107
Seattle, WA 98122
Phone: 206.296.6300
Fax: 206.296.6089

Patient Name:____ Former Name:_______________
Last *First* *MI*

Address:____
Street *City* *State* *Zip*

Phone: __________________________ DOB_________________ Student ID #__________________

I request and authorize the Seattle University Student Health Center to ☐ **obtain from** or ☐ **disclose to** (*check the appropriate box*) the following entities my health care information:

☐ **Seattle University Disability Services:** Phone: 206-296-5740, Fax: 206-296-5747

☐ **Seattle University Athletic Trainers:** Phone: 206-296-5452, Fax: 206-296-2154

☐ **Seattle University Counseling and Psychological Services:** Phone: 206-296-6090, Fax: 206-296-6096

☐ **SELF-***See contact information above*

☐ **Other Person/Organization Name**: ____

Address:____
Street *City* *State* *Zip*

Phone: _______________________ Fax: ____________________

To obtain or disclose the following health care information *(check all appropriate boxes):*

☐ ***All*** Health Records or
☐ ***Selected*** Health Records:
☐ Lab & diagnostic reports ☐ Imaging/X-Rays reports
☐ Immunizations ☐ Other (Please Specify): _________________________

In the format requested below: *(check appropriate box):*
☐ Mail ☐ Fax ☐ Fax ☐ Email ☐ Disclose health information verbally

For the following purpose(s)*(check appropriate box):*
☐ Coordination of Care ☐ Transfer of Care ☐ Insurance ☐ Legal
☐ Personal ☐ Other (specify):_______________________________________

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply**. I understand and agree that this information will be disclosed if I placed my initials in the applicable space next to the type of information:**

______ HIV/AIDS testing, diagnosis, treatment ______ Sexually Transmitted Disease
______ Mental Health diagnosis, treatment, referral ______ Reproductive Health Care
______ Drug/Alcohol diagnosis, treatment, referral

This Authorization to Disclose Health Care Information may be revoked at any time by providing written notice filed with the Student Health Center. This authorization shall expire upon the following date or events:____ (If no expiration date or event is listed, this authorization is valid for three years from the date on which it is signed.)
I hereby affirm that I understand the effects of signing this authorization and all my questions have been answered. I release Seattle University and its trustees, officers, employees and agents from any and all liability that may arise from release of my health care information. I understand that once the health care information is used or disclosed pursuant to this authorization, the information may be subject to redisclosure by the recipient and no longer protected. **By signing this page, I acknowledge that I have read and agreed to the terms of this Authorization to Disclose Health Care Information.**

Patient signature:____Date:__________________