Western Carolina University
Health Services
Bird Building
1 University Drive
Cullowhee NC 28723
828-227-7640(P) 828-227-7400(F)

Release of Information

Patient Name (Last, First) _____ Date of Birth _____ WCU Student ID Number _____

Address _____

City/State/Zip _____ Telephone ( ) _____

I authorize WCU Health Services to:

☐ **Release information to:** ☐ **Obtain my information from:** ☐ **Verbally communicate information with:**

Name/Organization _____

Address _____

City/State/Zip _____

Telephone _____ Fax _____

Please release or send the following information from my health record: (Check all that apply)

☐ Complete Medical History ☐ Women's Health (notes, pap, lab) ☐ Medical Treatment Summary
☐ Immunizations ☐ Laboratory Reports ☐ Medication/Prescription Records
☐ Physician Notes ☐ Gyn (Pap/Exam Results, Labs) ☐ ADD/ADHD Testing and Treatment Records
☐ Other: _____

Specify Date(s) of Service/Treatment: (all dates included unless otherwise indicated): _____

Purpose of Disclosure: ☐Continuation of Care/Treatment ☐ Personal Use ☐ Employment
☐ Insurance ☐Administration/Academic Coordination
☐ Other:_____

I understand this authorization applies to the items checked and is only valid through the date indicated on this form.
I understand that disclosure or release of information to anyone other than the named entities above require another authorization.
I understand information disclosed pursuant to this authorization may include HIV/AIDS, treatment for drugs/alcohol use, mental/behavioral health or psychiatric care.
I understand that I have the right to revoke this authorization at any time in wiring to WCU Health Services. The revocation will not apply to information already released/received in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.
I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
I understand that once the authorization is received the processing time for all health records is within 5 business days.
Unless otherwise revoked this authorization expires on _____. If no date indicated the authorization will expire 12 months from the date signed.

_____ _____/_____
Signature of patient or legal representative **Date** **If signed by legal representative/relationship to patient**

_____ **Delivery Method to Patient:** ☐ **Pick up** ☐ **Mail via USPS**
WCU Health Services Witness **Date** ☐ **Faxed** ☐ **Electronic Copy to Patient**

Updated 06/21/2021