



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) 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 writing 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
WCU Health Services Witness Date Delivery Method to Patient: Pick up Mail via USPS
Faxed Electronic Copy to Patient