

**AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI)**

Western Carolina University
Student Health Center
Cullowhee, NC 28723
Phone: (828) 227-7640 Fax: (828) 227-7400

Patient Name (Last, First) _____ WCU ID# (920#) _____ Date of Birth _____

Address _____

City/State/Zip _____ Telephone () _____

I authorize the Student Health Center to DISCLOSE Protected Health Information contained in my medical record To:

Name/Organization _____

Address _____

City/State/Zip _____

Telephone() _____ Fax() _____

I authorize the person (s) /facility below to release information contained in my medical record to the WCU Health Center:

Name/Organization _____

Address _____

City/State/Zip _____

Telephone() _____ Fax() _____

Information To Be Disclosed: (One or more boxes must be checked and dates must be specified)

- Immunizations Laboratory Reports Medication/Prescription Records
 Physician Notes Gyn (Pap/Exam Results, Labs) Other: _____

Specify Dates: _____

Reason for which I am authorizing disclosure: Continuation of Care Payment of a Claim Personal Use
 Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Student Health Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire _____; If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed. 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 also understand that the information disclosed according to this release may be redisclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

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

Official Use Only: Date received: _____ Person Assisting with Form Completion: _____
Release Method: Mail Fax Handcarry (date) _____