AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Seattle Pacific University Health Services, 3307 Third Avenue West, Suite 110, Seattle WA 98119
Phone: 206-281-2231 * Fax: 206-281-2674 *** Email: healthservices@spu.edu**

I (***Patient***) authorize the release of specific health information described below (***Information***) from Provider to Recipient pursuant to the terms of this authorization form (***Authorization***).

Patient Name: _____ Date of Birth: _____

Address: _____

SPU ID: _____ Phone: _____ Email: _____

Provider of Information (mark one): ☐ Seattle Pacific University Health Services
☐ Person or organization named below

Provider Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Recipient of Information (mark one): ☐ Patient named above
☐ Seattle Pacific University Health Services ☐ Person or organization named below

Recipient Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Delivery preference: ☐ Mail ☐ Pickup ☐ Fax

Purpose for release: ☐ Legal ☐ Insurance ☐ Medical Treatment ☐ Personal use
☐ Other: _____

Information to be released: (include a specific and meaningful description and range of dates, if known):

_____

_____

_____

The Information *should include* the following records (if no box is checked, then those records, if any, will **not** be included): ☐ HIV or sexually transmitted disease information; ☐ drug and alcohol abuse treatment information; ☐ mental illness or psychiatric disorders.

Duration and Revocation: Unless revoked, this Authorization expires on this date: _____ (90 days, if left blank). I may revoke this Authorization by submitting a written revocation to Provider. The revocation will not affect the release of Information before receipt of the revocation.

I voluntarily sign this Authorization. I authorize Recipient to receive and use the Information consistent with this Authorization. I have the right to receive a copy of this signed Authorization. Provider may destroy the original and copies of this Authorization as permitted by law. The Information disclosed under this Authorization may be subject to redisclosure and may no longer be protected by Federal privacy regulations.

_____

Signature of Patient Date

Office Use Only Identity Verified: [ ] School ID [ ] State ID [ ] Signature on File

Date Released: _____ Initials: _____ [ ] Fax [ ] Mail [ ] Hand-Delivered [ ] Verbal