## Authorization to Obtain or Release Records

Westminster College/Wellness Center/501 Westminster Ave./Fulton, Mo./65251/Phone: 573-592-5361/Fax: 573-592-5180

Name: _____ Date of Birth: _____

Address: _____

Phone: _____Email: _____

**1. Purpose of Authorization**

I authorize the College Health & Counseling Center to **obtain and/or release** my protected health information (PHI) as indicated below. (Please circle.)

**2. Type of Action (Check One)**

☐ Release my records to the individual/organization below

☐ Obtain records from the individual/organization below

☐ Two-way exchange of information

**3. Recipient / Provider Information**

Name / Organization: _____

Address: _____

Phone: _____ Fax: _____ Email:_____

**4. Information to Be Disclosed (Check All That Apply)**

☐ Entire Medical Record

☐ Women's Health Visit and lab results

☐ Immunization Records

☐ Medication List / Prescriptions

☐ Disability/Accommodation Information

☐ Visit Verification Only

☐ Counseling / Mental Health Records* (Sensitive information requires initials: _____)

☐ Laboratory Results * (Sensitive information requires initials: _____)

☐ Other (specify): _____

**Date range for disclosed information:** _____

**5. Method of Disclosure (Check All That Apply)**

☐ Verbal/Phone ☐ Printed copies ☐ Fax

☐ Secure email / encrypted email

☐ Other: _____

**6. Purpose of Disclosure (Check One or More)**

☐ Continuity of care ☐ Academic accommodations

☐ Coordination with outside provider ☐ Personal use

☐ Academic/Department requirement

☐ Other (specify): _____

**7. Expiration of Authorization**

This authorization is valid until:

Date: _____ (Will expire in one year if not listed.)

**8. Acknowledgment & Signature**

I understand that:

- This authorization is voluntary.

- I may revoke this release of information in writing at any time.

- Records disclosed may include sensitive information unless restricted by law.

- The College is not responsible for re-disclosure by the recipient.

Signature: _____Date: _____

Witness Signature: _____ Date: _____