THE WELLNESS CENTER
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ _____
(Patient Name - First, Middle, Maiden, Last) (Student ID) (Date of Birth)

_____ _____
(Address) (Phone Number)

Hereby authorize the Wellness Center at Westminster College to:

_____ Obtain from: Or _____ Release to:

___ Self
___ Callaway Community Hospital
___ Professors_____

___Dean of Student Life, Academic Affairs
___ Student Response Team

_____

___ Athletic Coaches and Staff_____

___Other: (include name, address, phone, and fax) _____

_____

_____

Please release from my medical and/or mental health records:

___ Entire Medical Records
___ Entire Mental Health Records
___ History and Physical
___ Medical Withdrawal Documentation

___Women's Health visit(s) and pap results
___ Lab reports
___Appointment Attendance
___Other_____

_____

Per federal regulation 42CFR part 2 and MSMO 191-656 a specific authorization is required to release sensitive information. If such information is contained in patient records, that information will not be released unless authorized below.

Specific data authorized release: HIV testing/results_____ Behavioral Health Records_____ Date_____ Provider Initials_____

Patient Signature_____

_____

I hereby release the Trustees of Westminster College, its officers, agents, representatives, and employees from any and all liability, claims or causes of action associated with the release of confidential client information in accord with this authorization. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. **This authorization is good for one academic year of my association with this practice, unless I revoke this authorization in writing. I understand that this release must be renewed each academic year. After the expiration date, this authorization will no longer be effective.**

_____ _____
(Signature of Patient) (Date of Signature)

_____ _____
(Signature of Witness) (Date of Signature)

If mailing records please send to the address below:

THE WELLNESS CENTER
WESTMINSTER COLLEGE
501 WESTMINSTER AVE.
FULTON, MO 65251-1299

Phone 573-592-5361
Fax 573-592-5180

***Please allow 5-7 working days to process your request**