AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Gonzaga Health & Counseling Services
502 E. Boone Avenue AD 106
Spokane, WA 99258
Phone 509-313-4052
Fax 509-313-5516

GONZAGA UNIVERSITY

Patient Information	Name:_____ (Last / First / Middle Initial / Maiden/Other) DOB: _____/_____/_____ Student ID #:_____ Phone # (____)_____
Clinic/Hospital/ Healthcare Provider (***Who*** has the information you want released?)	☐ Gonzaga Health & Counseling Services **OR** ☐ Other healthcare provider (list below) Name:_____ Address: _____ City/State/Zip:_____ Phone # (_____)_____ Fax # (_____)_____
Receiving Party (***Where*** do you want the information sent? ***Who*** should receive it?)	☐ Gonzaga Health & Counseling Services **OR** ☐ Myself, other provider, or person (list below) Name:_____ Address: _____ City/State/Zip:_____ Phone # (_____)_____ Fax # (_____)_____
Information to be Released (***What*** do you want sent or released? Check the appropriate boxes.)	☐ Medical Records ☐ Counseling Records ☐ Psychiatric Records ☐ Provider Notes ☐ Laboratory ☐ X-rays ☐ Medication Records ☐ Immunizations ☐ Billing Records ☐ All health care information in my record ☐ Other (please specify):_____ Optional limits—Disclose only records specifically related to the following: Dates of Service: _____ Injury or Illness: _____
Release Instructions (***How*** and ***When*** do you want the information?)	**Choose one:** ☐ To be picked up ☐ To be mailed ☐ To be faxed ☐ Verbal release only Date information is needed: _____ (***Note****: Please allow 10-15 business days for processing.)*
Purpose (***Why*** is it needed?)	☐ Personal Use ☐ Legal ☐ Continued care ☐ Academics ☐ Other (please specify):_____
Sensitive Records Authorization	I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released (check all that apply): ☐ HIV/AIDS ☐ Mental Health or Illness ☐ Sexually Transmitted Diseases ☐ Drug and/or Alcohol Abuse
My Rights	I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, enrollment, or eligibility for benefits). I may revoke this authorization in writing. To view the process for revoking this authorization, please read Privacy Notice to Patients posted in the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. This authorization expires immediately after the health information has been released to the recipient. It does not entitle the recipient to ongoing receipt of my health information.
Signature	I hereby authorize the release of the medical records specified above. I understand identification will be required before releasing information and that there may be charges associated with your request for records. _____ _____ ***Signature of patient*** ***(Hand-written signature only)*** ***Date***

Office Use Only: Date of Release: _____ / _____ / _____ Released by: _____

Instructions for Completion of This Form

Patient Information	Clearly and legibly complete the entire section with all of the demographic information specific to the patient (the person whose medical information is being requested).
Clinic/Hospital/ Healthcare Provider	Identify which clinic, hospital, or healthcare provider you are seeking information from. Please be specific in your request. If Gonzaga Health & Counseling Services has the health information you are requesting, you may check that box and leave the remainder of the lines blank. If another healthcare provider has the information you want, fill in that provider's information in this section.
Receiving Party	Identify where you want your health information to be sent. Please be specific in your request. If you want this information sent to Health & Counseling Services, you may check that box and leave the remainder of the lines blank. If you want this information sent to yourself, another person, or another healthcare provider, please fill in their full contact information. You need to complete separate forms for different destinations (e.g. if you want a copy and you want a copy sent to another doctor, you must complete a release for yourself and that doctor).
Information to be Released	Please give us instructions on what information you want released. We will disclose the information as you request it, so please be specific in your request. You can limit your request to a specific range of dates or to a specific illness or injury. If you are unsure which box to check, you can detail your request under "Other."
Release Instructions	This tells us how you would like the information delivered. Requests typically take 10-15 business days for processing. Please note: cannot send information via e-mail. We are also unable to provide you with CDs of imaging (e.g. x-rays); those must be directly requested from the imaging provider. If you are requesting that information be shared verbally, please note that this will apply to this single healthcare situation only and does not authorize ongoing exchange of information.
Purpose	Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).
Sensitive Records Authorization	There are certain conditions that require your specific acknowledgement in order for healthcare providers to release your health information. If your request includes health information in any of these four categories, you must have checked the appropriate box in order for this release to be processed.
My Rights	This section includes information about your rights as they pertain to the release of this health information.
Signature	We require a hand-written signature and date in order to release this information. We cannot accept an electronic signature of any kind.

For questions regarding this release form or your specific request, please contact us at:

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