Authorization To Release and/or Receive Copies of Psychiatry Records
The George Washington University Student Health Center

University Student Center, Ground Floor
800 21st Street, NW | Washington, DC 20052
P: 202-994-5300 | F: 202-994-2622
Healthcenter.gwu.edu

Submit this request to shs@gwu.edu
Submit payment at https://my.gwu.edu/mod/cse Reference ID#________________

- Psychiatric Records: $15
- Psychiatric Records Third party request: $30

**Please allow up to 14 business days to complete record requests for psychiatric records

Student/Patient Information

Name: ____
Date of Birth: __________________________(MM/DD/YYYY)
GWID: ____

I request and authorize the George Washington University Student Health Center ☐ to provide ☐ to receive copies of my psychiatric records, as outlined below, to and/or from the following entity/individual:

Name of Entity/Individual: ____
Address: ____
Phone: ____
Email: ____
Fax: ____

Scope of Authorization to Release Psychiatric Records[1]:

☐All Psychiatric Records
☐Psychiatric Records related to following visits: ____

PLEASE NOTE: if any record outlined above contains information regarding the student/patient's HIV/AID status, drug/alcohol abuse, or sexually transmitted disease, the student/patient is hereby authorizing disclosure of this information.

Purpose of Disclosure:

☐ To the Patient/Student ☐ For transition/continuity of health ☐ For payment/Insurance purposes
☐ For legal purposes ☐ Other: ____

Mode of Delivery (Select One):

☐Hold for Pickup ☐Email: ________________________ ☐Fax: ________________________
☐Mail to: ____

By signing below, I acknowledge and understand that:

- I am authorizing the University to release and/or receive a copy of my psychiatric records as outlined above.
- After the University Student Health Center discloses these records, the copies may no longer be protected by federal or local privacy laws.
- I have a right to inspect and receive a copy of the disclosed material.
- This authorization will expire upon fulfillment of this disclosure or earlier upon receipt of my written revocation to Immunreq@gwu.edu. I understand that revocation will not apply to information that has already been released in response to this authorization.
- This form is voluntary and I have the right to refuse to sign it. My treatment, payment, or eligibility of benefits will not be conditioned upon my authorization of this disclosure.

I represent and warrant that I have the authority to sign this document and authorize the disclosure and/or receipt of these records and that there are no claims or orders pending or in effect that would limit or restrict my ability to authorize this disclosure.[2]

Printed Name: ____
Signature: ____
Date: ____________________________________

[1]Signers other than the patient/student must present legal documentation that authorizes them to act as a Personal Representative.

Updated: July 2024