Colonial Health Center, Counseling and Psychological Services

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Print Name:

Last/Maiden: ______________________ First: ______________________ MI: __________

Date of Birth: ______________________ GWID#: ______________ Phone Number: __________

First Semester Term: ______________________ Last Semester Term: ______________________

Please check all that apply:

☐Current Student ☐Former Student ☐Doctor of Medicine ☐Health Sciences Program

I, the undersigned, request and authorize:

Colonial Health Center
Marvin Center, Ground Floor
800 21st Street, NW
Washington, DC 20052
P|202-994-5300~F|202-912-8488
Email: counsel@gwu.edu

**** The recipient of the mental health information cannot re-disclose the records without another authorization by the patient.**

☐ **To Provide to:**
Fees apply

☐ **To Receive From:**
Fees do not apply

Name: ____

Address: ____

____

Phone: ______________________ Fax: ______________________

Email: ______________________

The following information:

☐ **A Clinical Summary of all CAPS Visits** *$5.00
☐ **All CAPS Records** *$15.00 (Visits to CAPS at the Colonial Health Center)
☐ **All CAPS Records** *$15.00 (3rd party request)
☐ **Records Limited to CAPS visits on** (Specify Date(s)):______________________
☐ **A Clinical Summary of CAPS visits limited to visits on** (Specify Date(s): ______________________

☐ Mail
☐ Fax
☐ Email
☐ Hold for Pickup on:

Allow **5-7business** days for processing this request.
Please visit https://my.gwu.edu/mod/cse/ to make payment and enter the reference ID number below in order to process.

Reference ID: ______________

****CAPS recommends students schedule a records review meeting with a CAPS clinician when requesting comprehensive CAPS records****

I authorize and request for my sole benefit the release of the above medical information which is a part of my file in the Colonial Health Center at The George Washington University. In addition, I hereby authorize The George Washington University to discuss the medical records identified above with the person(s) identified above. I understand I have the right to refuse to sign this form, and that I may revoke my authorization in writing at anytime (except to the extent that the information has already been released). This authorization will expire on the following date or event: If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed. I hereby completely and fully release and discharge The George Washington University of any and all liability for furnishing the information requested.
Description of “Other” information to be incorporated into my “Authorization for Release of Medical Records”: All health care information, reports and/ or records concerning my medical history, status, admittance, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

The patient has the right to inspect his/her/their mental health record.

Patient Signature ______________________________ **Date** ______________

Parent/Guardian Signature (if patient is under 18) ______________________ **Date**______________

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FOR OFFICE USE ONLY
Mailed ☐ Faxed ☐ Picked up CHC Initials:_____ Date:______ Date :_____ Payment Received: Initials_____