THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

Colonial Health Center

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

AUTHORIZATION FOR RELEASE OF PSYCHIATRIC RECORDS

I, the undersigned, request and authorize:

Colonial Health Center
University Student Center, Ground Floor
800 21st Street, NW
Washington, DC 20052
P|202-994-5300~F|202-242-9922
Email|shs@gwu.edu

☐ **To Provide to**:
Fees apply

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

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

The following information:

☐ **Partial Psychiatric Records** *$5.00 Limited to visit on (Specify Date): _____

☐ **All Psychiatric Records** *$15.00 (Visits at Colonial Health Center)

☐ **Other**

☐ Mail

☐ Hold for Pick Up on _____

Allow **5 business** 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: _____

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 understand this release does not include any mental health records. 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.

Patient Signature _____ **Date** _____

FOR OFFICE USE ONLY

☐ Mailed ☐ Picked up SHS Initials:_____ Date:_____ Payment Received: Initials_____ Date:_____