Authorization To Disclose Personal Health Information from Medical 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: F: 202-242-9922
Healthcenter.gwu.edu

Submit this request to Immunreq@gwu.edu

Student/Patient Information
Name: ____
Date of Birth: ___________________________(MM/DD/YYYY)
GWID: ____

I request and authorize the George Washington University Student Health Center to disclose personal health information contained in my medical records with the following entity/individual:

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

Scope of Authorization to Release Personal Health Information from following Medical Records[3]:
☐Immunization Records ☐PPD/TB Skin Test Results ☐All Medical Records
☐Medical 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:
☐ Patient/Student Request ☐ For transition/continuity of health ☐ For payment/Insurance purposes
☐ For legal purposes ☐ Other: ____

Expiration Date:
This authorization will expire on _______________________________or one year from the date of signature below, whichever is earlier ("Expiration Date"). This authorization may also be revoked upon receipt of the student's written revocation (see below).

By signing below, I acknowledge and understand that:

- I am authorizing the University to disclose personal health information from my medical records as outlined above.
- After the University Student Health Center discloses this information, it may no longer be protected by federal or local privacy laws.
- I understand that this authorization will expire on the date outlined above 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 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.[4]

Printed Name: ____
Signature: ____
Date: ______________________________________

[3] Information from Psychotherapy and Psychiatric Care Records may not be released utilizing this form.
[4] Signers other than the patient/student must present legal documentation that authorizes them to act as a Personal Representative.