Authorization To Release Copies of CAPS Medical Records
The George Washington University Student Health Center

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THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Submit this request to **counsel@gwu.edu**
Submit payment at https://my.gwu.edu/mod/cse Reference ID#_____

- A Clinical Summary* of all CAPS Visits: **$5**
- All CAPS Records* (Visits to CAPS at the Student Health Center) / Third Party Requests: **$15**

*CAPS recommend students schedule a records review meeting with a CAPS clinician when requesting comprehensive CAPS records
**Please allow up to 14 business days to complete record requests

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

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

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

Scope of Authorization to Release CAPS Medical Records[1]:
☐All CAPS Records
☐A Clinical Summary of all CAPS visits
☐A Clinical Summary of CAPS Medical Records related to following visits: _____
☐CAPS Medical Records related to following visits: _____

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 a copy of my medical 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 by request.
- This authorization will expire upon fulfillment of this disclosure or earlier upon receipt of my written revocation to counsel@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.[2]

Printed Name: _____
Signature: _____
Date: _____

[1] Medical, Immunization, and Psychiatric Care Records may not be released utilizing this form. The recipient of the mental health information cannot re-disclose the records without another authorization by the patient.
[2] Signers other than the patient/student must present legal documentation that authorizes them to act as a Personal Representative.