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| --- | --- |
| http://www.mariacollege.edu/sites/default/files/logo.jpg | Department of Student Affairs |
| 518-861-2508  |
| FAX 518-730-9628 |
| Student Support Center, Mercy Hall |

**Authorization for the Release of Protected Health Information**

By signing this form, I hereby authorize the release of protected health information by Maria College.

Patient/Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To the following individual or organization*

Name of person or organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The purpose of the disclosure*

􀂅 Personal Need 􀂅 Coordination of care

􀂅 Assistance with academic concerns 􀂅 Assistance with mental health concerns

􀂅 To assist with 504 accommodation(s) 􀂅 Legal investigation

􀂅 Professional consultation

􀂅 For medical withdrawal or assessment for return

􀂅 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Information to be disclosed*

􀂅 Disability Information/Diagnosis 􀂅 Medical Diagnosis

􀂅 Therapeutic Treatment

􀂅 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the following:

1. I may revoke this authorization at any time. The revocation will not apply to information that has already been released in response to this authorization. I must revoke this authorization in writing.
2. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment in any way.
3. Information disclosed to other campus programs (including the programs highlighted above) or to a healthcare provider, in accordance with my authorization, cannot be further disclosed by the recipient without my written consent, unless otherwise authorized by law. (this written consent covers the sharing of information between the parties that are checked above, on an “need to know” basis).
4. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, it is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law and the information may be re-disclosed.
5. This authorization covers the right for your information to be shared in a Clinical Supervisory capacity for review of clinical records by a licensed clinical professional for the purpose of evaluation of appropriate care.

*Expiration Date*

Unless otherwise revoked, this authorization will expire on (*date or event*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I fail to specify an expiration date or event, this authorization will expire one (1) year from the date of my signature.

Patient/Student Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness/counselor Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_