Department of Student Affairs
518-861-2502
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
- ☐ Assistance with academic concerns
- ☐ To assist with 504 accommodation(s)
- ☐ Professional consultation
- ☐ For medical withdrawal or assessment for return
- ☐ Other ____
- ☐ Coordination of care
- ☐ Assistance with mental health concerns
- ☐ Legal investigation

Information to be disclosed

- ☐ Disability Information/Diagnosis
- ☐ Therapeutic Treatment
- ☐ Other ____
- ☐ Medical Diagnosis

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 ____________________