Office of Accessibility Services
518-861-2583
Fax: 518-730-9628
Student Support Center, Mercy Hall

Authorization for the Release of Protected Health Information

By signing this form, I

Student name: _____ Student ID number: _____

Date of birth: _____ Email: _____ Phone: _____

Address: _____

hereby authorize Maria College to release the following protected health information

- ☐ Disability information/diagnosis (or diagnoses)
- ☐ Other diagnosis (or diagnoses)
- ☐ Therapeutic treatment
- ☐ Other: _____

_____

to the following individual or organization

Name of person or organization: _____

Email: _____ Phone: _____ Fax: _____

Address: _____

for the following purpose(s).

- ☐ Assistance with academic concerns
- ☐ Assistance with mental health concerns
- ☐ Coordination of care
- ☐ For medical withdrawal or assessment for return
- ☐ Legal investigation
- ☐ Personal need
- ☐ Professional consultation
- ☐ To assist with 504 accommodation(s)
- ☐ 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 a "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

Unless otherwise revoked, this authorization will expire on (date or event): _____

_____

If I do not specify an expiration date or event, this authorization will expire one (1) year from the date of my signature.

Student/patient name (printed): _____

Student signature: _____ Date: _____

Witness/counselor name (printed): _____

Signature: _____ Date: _____