WASHINGTON COLLEGE

AUTHORIZATION FOR THE RELEASE OF HEALTH &/or COUNSELING INFORMATION

Student ID Number:_____

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at *42* CFR § *164.508* and the Annotated Code of Maryland, Title 10 Health General Article §§ *4-301 – 4-307.*

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize Washington College Health Services to release the protected health information of:

PATIENT: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____

_____

The information is to be released to:

NAME:_____

ADDRESS: _____

PHONE #: _____ FAX #: _____

The information I wish to have released is (include dates of service):

_____

- ☐ Discharge summary
- ☐ History and physical exam
- ☐ Reports of operations
- ☐ Imaging reports
- ☐ Consultation reports
- ☐ Immunization Records
- ☐ Diagnostic cardiology reports
- ☐ Laboratory reports
- ☐ Other: _____

I do ___I do not___wish to have information about HIV/AIDS released under this authorization.

I do ___I do not___wish to have mental health records released under this authorization.

I do _____I do not_____wish to have information about drug/alcohol abuse treatment released under this authorization.

If Washington College Health Services is in possession or records from another provider,
I do _____ I do not _____ wish to have those records released under this authorization.

The purpose for such disclosure is:

- ☐ At my request (only patient may check)
- ☐ Health Care
- ☐ Other: _____
- ☐ Payment/Insurance
- ☐ Employment/Internship
- ☐ Clearance for college related travel

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This authorization will expire one year from the date it is signed unless a shorter time is indicated here:

_____

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify Washington College Health Services in writing.
- I understand that once information covered by this authorization has been disclosed redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

_____ _____ _____

Patient or Personal Representative's Signature *Date* *Relationship*

If signature other than patient, provide proof of authority, and explain your authority to act for the patient:

_____

_____

_____

_____

_____

_____

_____ _____

Witness Date

Proof of ID provided: _____

If there is a question or concern with responding to this authorization, you will be contacted by Washington College Health Services Privacy Official to discuss it. Questions or complaints about the federal privacy regulations or policies and procedures relating to these federal regulations should be directed to Washington College Health Services Privacy Official.