HAVERFORD
COLLEGE

HEALTH SERVICES

HIPAA AUTHORIZATION FOR RELEASE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Legal Name: Student ID:

Date of Birth:

Address:

Phone:

I, ___________________________, authorize Haverford College Student Health Services to:

☐ **OBTAIN** my protected health information the following recipient:
☐ **DISCLOSE** my protected health information to ☐ **Me** or to:

Name of Person(s) and/ or Name of Organization:

Address:

Phone:

Fax:

Relating to the following treatment or condition:

☐ History & Physical
☐ Consultation Report
☐ Progress Notes
☐ Clinical Notes
☐ Lab Reports
☐ Diagnostic Imaging (XRAY, Cat Scan, Ultrasound, etc.)
☐ Immunizations
☐ STI/ STD Screenings
☐ Other: _______________

Covering the period(s) of treatment ____________________ to ____________________.

Disclosure of Sensitive Information:

You have the right to refuse disclosure and prevent any other person from disclosing sensitive information related to the following conditions, treatments, or testing. Include (by checking boxes below): Please note that the information will not be release if not checked.

☐ Alcohol/ Drug Treatment/ Testing
☐ HIV/ AIDS Related Information
☐ I authorize the disclosure of ALL sensitive information.
☐ I DO NOT authorize the disclosure of ANY sensitive information.

Comments/ Notes: ____.

Purpose/ Use of the Requested Information:

☐ Continuation of Medical Treatment
☐ Personal use by patient
☐ School/ Job Purposes
☐ Legal Purposes
☐ Insurance Purposes
☐ Other: _______________

Authorization expires:

☑ - 1 year from date of authorization
☐ - Other Date or Event: ____________________

My Rights:

I understand that I may refuse to sign this Authorization, and my refusal will not affect my ability to obtain treatment, eligibility for benefits, or payment for health care services.

I understand that I may revoke this Authorization at any time, but my revocation will not change any uses, disclosures, or other actions already taken based upon my original permission. In order to cancel I must do so in writing and send it to Health Services at the address set forth above.

I acknowledge that I will receive a signed copy of this Authorization after I have signed it.

I understand that health information disclosed pursuant to this Authorization in some instances could be legally re-disclosed by the recipient without my knowledge and in such cases may no longer be protected by federal confidentiality law (HIPAA).

Signature of Patient: Date:

Signature of Witness: Date: