AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Swarthmore College Student Health & Wellness 500 College Avenue, Swarthmore, PA 19081 Phone 610-328-8058 Fax 610-690-5724

I understand that my medical record may contain information (including medications) related to alcohol/drug abuse and/or dependence, behavioral/health rehabilitation, HIV and/or AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information not be disclosed by initialing below:

_____Alcohol/Drug Abuse and/or Dependence _____Behavioral Health/Rehabilitation _____HIV and or AIDS _____Sexual Assault

_____ _____ _____

Patients Name(Last,First) Swarthmore ID# Date of Birth

Address_____

City/State/Zip_____Telephone_____

I authorize Swarthmore College Health Services to DISCLOSE/RECEIVE Protected Health Information contained in my medical record TO/FROM:

Name/Organization_____

Address_____

City/State/Zip_____

Telephone_____ Fax_____

Information To Be Disclosed/Received: (One or more must be checked and dates must be specified)

___Immunizations ___Treatment Notes ___Laboratory/Pathology Reports ___Radiology ___Physical Therapy Notes

Other_____

Dates: ___/___/___ through ___/___/___: Time period for which information to be released can be found in my medical record.

Reason for which I am authorizing disclosure/receival:

_____Continuation of Care _____Payment of a Claim _____Personal Use _____other:_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Swarthmore College Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire 90 days after it is signed or sooner if requested by the patient. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I also understand that the information disclosed according to this release may be redisclosed by the recipient and is no longer protected by HIPAA (Federal Regulations).

_____ _____ _____

Signature of patient or legal representative Date If signed by legal representative, relationship to patient