ROBERTS WESLEYAN COLLEGE

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION - PHI

As required by the Health Insurance Portability and Accountability Act, HIPAA Privacy Rule (45 CFR § 164.500-534), Roberts Wesleyan College may not use or disclose your protected health information except as provided in our Notice of Privacy without your authorization. In order to share your Protected Heath Information (PHI) with others you stipulate; please complete, sign, date, and return the authorization form to the Health Center.

Name: _____ Birthdate: _____ /_____ /_____

Address: _____ Last four digits of SS#: _____

City: _____ State: _____ Zip: _____ Phone: _____

I authorize Roberts Wesleyan College Health Center, 2301 Westside Drive, Rochester, NY 14624

❑ Disclose to ❑ Obtain from

Name: _____

Organization: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

The Protected Health Information as appropriately indicated:

❑ My complete health record (includes all the items listed below)

OR *(✓appropriate boxes below to be released)*

❑ Immunization Records ❑ Health history & physical ❑ GYN records ❑ Substance abuse/alcohol treatment
❑ HIV related information ❑ Mental health records ❑ Emergency Department Records
❑ Laboratory Report(s) ❑ Pathology Report(s) ❑ Operative Report(s) ❑ Radiology Report(s)
❑ Other (Please specify) _____

Physician, Hospital, Emergency Department, Urgent Care Visit Dates: _____

Purpose of request: (Describe in detail)

❑ College ❑ Health Care (Continued care with physician) ❑ Employment ❑ Insurance Coverage ❑ Personal

❑ Other: _____

Form of Disclosure: ❑ Access Patient Portal ❑ Mail hard copy ❑ Fax copy

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Duration of authorization: This authorization to share my PHI is valid from _____/_____/_____ to _____/_____/_____

I acknowledge that I have the right to inspect a copy of the Notice of Privacy Practices, to restrict what is disclosed, to revoke this authorization at any time by sending written notification to the Roberts Wesleyan College Health Center staff. I understand the revocation of this authorization is not effective if the Health Center has used the authorization for disclosure of PHI before receiving my written revocation notice. I undertand failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving treatment or benefits I am entitled to, provided this information is not required to determine if I am eligible to receive those treatments or benefits. I understand that any PHI disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that I may request a copy of this authorization. I understand, if any sections are left blank, this form will be invalid and the request to share my private health information will not be completed.

_____ _____ / _____ / _____

Signature of Student or Student's Authorized Representative *Today's Date*