



AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

When you complete this form, you are authorizing the disclosure and/or use of your protected information, as described below, consistent with state and federal laws concerning privacy of such information. If you do not provide all the information requested, this authorization may not be valid.

Print Student Name: _____

Student ID Number: _____ Date of Birth: _____

AUTHORIZATION FOR DISCLOSURE FOR HEALTH INFORMATION

I hereby authorize the staff in the Disability Resource Center to:

☒ Release my health information to:

☒ Obtain my health information from:

1. _____
Name Relationship Phone
2. _____
Name Relationship Phone
3. _____
Name Relationship Phone

PURPOSE OF REQUESTED USE OR DISCLOSURE

Disability Related Services for College

INFORMATION THAT MAY BE USED OR DISCLOSED THROUGH THIS AUTHORIZATION

☒ All clinical information ☐ Clinical information from _____ to _____

☐ Other: _____

☐ Exceptions: _____

NOTICE OF RIGHTS AND OTHER INFORMATION

I understand that I may take back (revoke) this authorization in writing at any time, except to the extent that the BCC Disability Resource Center has taken action in reliance on this authorization. I understand that, to revoke this authorization, I must send a letter to the BCC Disability Resource Center .

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the Disability Resource Center .

I understand that if the person or entity that receives my protected health information is not required to comply with the federal privacy regulations, the information I have released may be redisclosed and would no longer be protected by these regulations.

This authorization expires (date or event): _____
(If not specified, this authorization expires one year from date of signature).

Student's Signature

Date

Print Student's Name

When a student is not competent to give consent, the signature of a parent, guardian, health care agent (proxy), or other representative is required.

Signature of Legal Representative

Date

Print Legal Representative's Name

Relationship of Representative to Student