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

Patient 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 ( ) _____ *Emergency situations only

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

☐ **Immunizations** ☐ **Treatment Notes** ☐ **Laboratory/Pathology Reports** ☐ **Radiology Reports** ☐ **Physical Therapy Notes**

☐ **Other:** _____

___/___/___ **through** ___/___/___ : *Time period for which information to be released can be found in my medical record.*
(Date) (Date)

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 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 _____

Official Use Only: Date received: _____ Person Assisting with Form Completion: _____

Release Method: ☐ Mail ☐ Fax ☐ Hand carry (date) _____