AUTHORIZATION FOR USE/DISCLOSURE/RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

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

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_____ _____ _____
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) _____