WASHINGTON COLLEGE

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION TO WASHINGTON COLLEGE

Student ID Number:_____

To:_____

_____

_____

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§ 4-301 – 4-307.

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize to release the protected health information of:

NAME:_____

PHONE:_____DATE OF BIRTH: _____

ADDRESS: _____

_____

The information is to be released to:

WASHINGTON COLLEGE
Health and Counseling Services
300 Washington Avenue
Chestertown, MD 21620
Ph: 410.778.7261 / Fax: 410.810.7101

The information I wish to have released is (include dates of service):

_____

Check records below that you want to be included.

_ Discharge summary
_ History and physical exam
_ Consultation reports
_ Reports of operations
_ Imaging reports
_ Diagnostic cardiology reports
_ Laboratory reports
_ Immunization Records

I do ___I do not___wish to have information about HIV/AIDS released under this authorization.

I do ___I do not___wish to have mental health records released under this authorization.

I do ___I do not_____wish to have information about drug/alcohol abuse /treatment released under this authorization.

If the office I am authorizing to release information is in possession or records from another provider,

I do _____I do not _____ wish to have those records released under this authorization.

WASHINGTON COLLEGE

The purpose for such disclosure is:

_ At my request (only patient may check)
_ Health Care
_ Other _____

_ Payment/Insurance
_ Employment/Internship

This authorization will expire one year from the date it is signed unless a shorter time is indicated here:
_____

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify the office I authorized to release my information in writing.
- I understand that once information covered by this authorization has been disclosed redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

Patient or Personal Representative's Signature:_____

Date:_____

If signature is other than patient, provide proof of your authority, and explain your authority to act for the patient:

_____

_____

_____ _____

Witness Date

Proof of ID provided:_____

If there is a question or concern with responding to this authorization, you will be contacted by Washington College Health Services Privacy Official to discuss it. Questions or complaints about the federal privacy regulations or policies and procedures relating to these federal regulations should be directed to Washington College Health Services Privacy Official..