AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION

This Authorization affects your rights in the privacy of your personal health care information. Please read it carefully before signing.

The College will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.**

This Authorization shall expire upon the earlier occurrence of: (a) your revocation of the Authorization; (b) complete satisfaction of the purposes for which this Authorization was originally obtained (to be determined in the reasonable discretion of the College), or (c) six (6) years from the date that you signed this Authorization.

By signing this Authorization, you acknowledge and agree that any information used or disclosed pursuant to this Authorization could be at risk for redisclosure by the recipient.

1. _____ _____
Name of Patient | Date of Birth

_____ _____
Street Address | City, State, Zip

_____ _____
Dates of Attendance | Month and Year of Graduation

2. AUTHORIZES:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

3. TO RELEASE MY INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

4. INFORMATION TO BE RELEASED:

___ Medical History, Examination, Reports
___ Treatment or Tests
___ Immunizations
___ X-ray Reports
___ Laboratory Reports
___ Entire Record
___ Surgical Reports
___ Hospital Records Including Reports
___ Allergy Records
___ Prescriptions
___ Consultations
___ Other (Specify): _____

In compliance with Massachusetts law, which requires special permission to release otherwise privileged information, please release records pertaining to:

___ Mental Health
___ Alcoholism
___ HIV (AIDS)
___ Other (Specify): _____
___ Developmental Disabilities
___ Drug Abuse
___ Sexually Transmitted Diseases

FOR THE FOLLOWING DATE(S): _____

5. PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___ Further Medical Care ___ Personal
___ Insurance Eligiblity/Benefits ___ Changing Physicians
___ Legal Investigation or Action ___ Other (Specify): _____

6. I understand that if the recipient person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who are subject to the federal privacy standards under HIPAA (the Health Insurance Portability and Accountability Act of 1996), the recipients may re-disclose the information disclosed to them pursuant to this Authorization without obtaining my authorization.

7. Your Rights with Respect to This Authorization

- **Right to Request and Inspect or Copy the Health care information to Be Used or Disclosed -** I understand that I have the right to request to inspect or copy the health care information I have authorized for disclosure by this authorization form. I may arrange to inspect or obtains copies of my health care information by contacting Worcester State College, Student Health Services.
- **Right to Request and Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I can be provided with a signed copy of the form upon my request.
- **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
- **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Worcester State College, Student Health Services. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health care information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

8. Expiration Date: This authorization is valid until the following date(s) _____
or events (s) (specify event) _____

9. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Print Name of Patient: _____

Signature of Patient: _____ Date: _____
(If signed by person other than patient, state relationship and authority below.)

Patient is: □ Minor □ Incompetent □ Disabled □ Deceased

Legal Authority (if signed by person other than patient):

□ Custodial Parent □ Legal Guardian □ Executor of Estate of Deceased

□ Power of Attorney for Health/Medical Care □ Authorized Legal Representative