



STUDENT AUTHORIZATION OF MEDICAL INFORMATION

I, _____, _____, _____,
Student Name SS Number Date of Birth

Hereby authorize _____ to disclose the following specific health information

_____ Covered Entity
_____ to _____ at my request to _____
Date Date Name and address

Specific description of information to be disclosed and purpose for disclosure: _____

The following information to be disclosed, as applicable (check all that apply):

- CONFIDENTIAL HIV AND AIDS-RELATED INFORMATION
- CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION
- CONFIDENTIAL MENTAL HEALTH DIAGNOSIS TREATMENT INFORMATION
- CONFIDENTIAL GENETIC TESTING INFORMATION

I hereby release anyone disclosing or receiving the records or information specified above pursuant to this authorization from any and all liability arising from that disclosure. I understand that I may revoke this authorization by writing, to the entity, at any time, except to the extent that action has been taken in reliance upon it. With respect to all information other than HIV and AIDS-related information, this authorization will expire on the earlier of three hundred –sixty-five (365) days after the date of this signature or the following expiration date, _____. With respect to HIV and AIDS -related information, this authorization will expire six months from the date of signing, or the expiration date, whichever is earlier.

I understand that the covered entity may not condition treatment, payment enrollment or eligibility for benefits on whether I sign this authorization. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

Date: _____ Signature of Patient: _____
Witness: _____

If patient is unable to give consent because of physical condition or age, complete the following:

Patient is a minor (____ year of age), or is unable to give consent because _____

Date: _____ Signature of Parent/Guardian/POA: _____
Relationship: _____ Witness: _____

PROHIBITION OF REDISCLOSURE: If information disclosed relates to substance abuse treatment, the confidentiality of these records is protected by federal law. Federal regulations (42 CFR Part2) prohibit any further disclosure without the specific written consent of the person to whom it pertaining or is otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rule restricts any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient records.