DORDT
STUDENT HEALTH AND
COUNSELING CENTER

# Authorization for Disclosure of Protected Health Information

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|---|---|---|---|
| **Patient Identification** | Name: | | Date of Birth: |
| | Address: | | Phone: |
| | City/State: | | Zip Code: |
| | Maiden/Previous Names/Nicknames: | | |
| **Provider (Who is releasing information)** | Provider | | Phone: |
| | Address: | | Fax: |
| | City/State | | Zip Code: |
| **Disclose Information to: (Where is information to be sent?)** | Name/Facility: | | Phone: |
| | Address: | | Fax: |
| | City/State: | | Zip Code: |
| **Information to be Disclosed** | ___Progress Notes | ___ Other (Specify) | |
| | ___ Physician's | ___ Other (Specify) | |
| | ___ Nurse's | ___ Other (Specify) | |
| | ___Supporting Lab Data | ___Other (Specify) | |
| **Service Dates** | Time Period From: | | |
| | Concerning: | | |
| **Purpose of Disclosure** | ___ Continuing Medical Care | ___ Consult/Second Opinion | ___ Attending College |
| | ___ Legal | ___ Personal | |
| **Revocation** | I understand that I may revoke this authorization at any time by sending a written notice to Dordt University Student Health & Counseling Center. | | |
| **Expiration Date** | The authorization will expire one year from the date of the signature. | | |
| **Authorization** | I hereby authorize _____Dordt University Student Health & Counseling Center____to disclose medical information concerning the above named patient to the recipient identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment: receive payment; or eligibility for benefits.<br><br>_____ _____<br>Signature of patient/ representative Signature Date | | |