Authorization for the Release of Protected Health Information

Name of person executing this authorization: _____DOB_____

I hereby authorize _____ to release health information about me to the Gettysburg College Health Service.

Date of Service: _____

The information to be released shall include the following:

- Medical Record (complete); History and Physical; X-Ray, Imaging Reports; Consultation Reports; Laboratory Test Results; Discharge Summaries (including those from other health care facilities received by the Gettysburg College Health Center)
- Other(please specify)_____

I understand that the purpose for this disclosure is to enable the Gettysburg College Health Service to coordinate my health care, housing, dietary and other specialized living needs in conjunction with any health care provided by the above named health care provider(s)/institution

This information will be released in the following manner:

[ ] In person **[ ]** Mail or other delivery service **[ ]** Fax **[ ]** E-mail

[ ] Other (please specify): _____

I understand that, to the extent that my medical record contains such information, this disclosure will include:

[ ] Information relating to AIDS or HIV infection
[ ] Treatment for substance and/or alcohol abuse or dependency
[ ] Psychotherapy notes, or other information relating to mental health or psychiatric care

This information is being disclosed to the Gettysburg College Health Service from records whose confidentiality may be protected by the Pennsylvania Drug and Alcohol Abuse Control Act, the Pennsylvania Mental Health Procedures Act, and/or the Pennsylvania Confidentiality of HIV Related Information Act. My signature below authorizes the release of information protected by these Pennsylvania statutes.

I understand that I have no obligation whatsoever to disclose information from my record, and that treatment cannot be withheld from me based upon my failure to execute this authorization, unless the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information.

I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. ***Specifically, I understand that once the Gettysburg College Health Service receives my health information from the above named, the Gettysburg College Health Service may, if authorized in writing by me to do so, further disclose this information as needed to assist with my educational and living needs at Gettysburg College.*** I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. The above named provider(s)/institution, its employees, officers and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from the above named provider(s)/institution upon request.

THIS AUTHORIZATION SHALL EXPIRE ON ___/___/20___, BUT IN NO EVENT SHALL THIS AUTHORIZATION EXPIRE MORE THAN ONE YEAR FROM THE DATE THIS AUTHORIZATION IS EXECUTED.

_____ _____
Patient or Patient Representative Date

If signed by Patient Representative, please describe power/authority to act on Patient's behalf:
_____

This document shall be kept on record for at least six years from the date above. ***01/07***