COUNSELING & WELLNESS SERVICES

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Counseling & Wellness Services at LIM College to disclose the protected health information of:

Patient/Student Name________________________ Student ID#_______________ Date of birth__________

Address __________________________________ Telephone_____________________________________

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To the following individual or organization:

Name of person or organization____

Address____

Phone_____________________________________ Fax____

The purpose of the disclosure:

☐ Personal Use ☐ Coordination of care ☐ Continuity of care
☐ Assistance with academic concerns ☐ To assist with 504 accommodation(s) ☐ Legal investigation
☐ Professional consultation ☐ For medical withdrawal or assessment for return
☐ Other ____

Information to be disclosed:

☐ Treatment dates ☐ Assessment ☐ Treatment Summary
☐ Recommendations ☐ Written Records ☐ Immunization Records
☐ Other ____

I understand that:

1. I may revoke this authorization at any time. The revocation will not apply to information that has already been released in response to this authorization. I must revoke this authorization in writing.
2. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment in any way.
3. Information disclosed to a healthcare provider or health plan, in accordance with my authorization, cannot be further disclosed by the recipient without my written consent, unless otherwise authorized by law.
4. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, it is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law and the information may be re-disclosed.

Expiration Date:

Unless otherwise revoked, this authorization will expire on (*date or event*) ________________________________
If I fail to specify an expiration date or event, this authorization will expire one (1) year from the date of my signature.

Patient/Student Name (Printed)____

Student Signature____Date_____________________________

Witness Name and Relationship to Patient/Student (Printed)____

Witness Signature____Date____________________________