St. John Fisher College Health and Wellness Center
HIPAA Privacy Authorization Form
Authorization for Use or Disclosure of Protected Health Information

Student Name	Date of Birth
SJFC ID# @	SSN, last 4 digits

I authorize the St. John Fisher College Health and Wellness Center to release information to:

Name of Provider or Facility
Address
Phone
Fax

OR

I authorize the following provider or facility to release information to the St. John Fisher College Health and Wellness Center:

Name of Provider or Facility
Address
Phone
Fax

Purpose of this request: ☐ Health Care ☐ Insurance Coverage ☐ Personal ☐ Other:_____

I authorize the release of:

☐ My complete health record (*including records relating to sexually transmitted disease, AIDS, or HIV, mental health services and the treatment of alcohol or drug abuse*)

☐ Specific office visit on_____ (date) ☐ Immunization records ☐ Health history and physical

☐ Lab/test results on_____ (date) ☐ Substance abuse/alcohol treatment ☐ GYN records

☐ Mental health records_____ (date) ☐ Mental health records: ALL ☐ HIV related information

☐ Other:_____

Expiration:

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

By signing below I indicate that I understand:

- that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of student/patient or personal representative Date

_____

Printed name of student/patient or personal representative and his or her relationship to patient Date