Bates | HEALTH SERVICES
A CMHC PARTNERSHIP

Authorization for Release of Student Health Information

Student Name: _____ Today's Date: _____
(Print Name Used at Time of Service)

Date of Birth: _____ Phone Number: _____ Class Year: _____

I hereby request the release of my health information *(please select the authorized disclosures below).*

I. Release to Student/Parent/Guardian

___ I authorize Bates Health Services to release to me ___ , my parents ___ , my legal guardian ___ for review ___ for copying ___ the medical records identified in Part III below.

_____
(Print name, address/fax/email of recipient)

II. Release to Bates Health Services/Provider/Other Third Party

___ I hereby authorize the providers and/or other third parties listed below to verbally communicate, send and/or receive the medical information listed in Part III below to Bates Health Services (at the address below).

___ I hereby authorize Bates Health Services to verbally communicate, send and/or receive the medical information listed in Part III below to the following providers and/or third parties:

Bates Health Services
31 Campus Ave
Lewiston, ME 04240
Fax 207-755-5838; Phone 207-786-6199
Email healthservices@bates.edu

Name: _____
Address: _____
_____
Fax/Phone: _____
Email: _____

III. Medical Records to be Released

I hereby authorize the disclosure of the following information (check authorized disclosures):

___ Medical History/Physical Examinations
___ Laboratory results/Diagnostic records
___ Treatment notes and records (other than relating to substance abuse, mental health or HIV treatment)
___ Treatment notes and records received from other healthcare providers/facilities
___ Claims and payment records
___ Notes and records of treatment or diagnosis of drug or alcohol abuse
___ Notes and records of treatment or diagnosis of mental health
___ Notes and records of treatment or diagnosis of HIV infection, ARCS or AIDS

___ Other (Describe): _____

Date(s) of Service(s):_____

Reason(s) for Service(s):_____

I (___DO ___ DO NOT) want to review this information before it is released. I understand that reviews must be supervised.

IV. Important Information about your Rights

• I understand that this authorization is voluntary and that I am not required to sign this form to receive any health care benefits (enrollment, treatment, or payment). I understand that I may refuse authorization to disclose all or some health care information, but that refusal my result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other adverse consequences.

• I may revoke this authorization at any time prior to its expiration date by written notice to any entity by or to which disclosure has been authorized. Any such revocation will not have any effect on actions taken by that the entity before it received the revocation. Any such revocation could be the basis for a denial of health benefits or other insurance coverage or benefits.

• I may see and copy the information described on this form if I ask for it.

• This authorization will be retained as part of my healthcare information and I am entitled to a copy of this authorization form upon request.

• Unless specifically provided above, the information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

• I understand that medical information held by the Bates College Health Services is considered "treatment records" under the Family Educational Rights and Privacy Act (FERPA) and that by reviewing my medical records and/or allowing for the disclosure of my medical information I am making these records "Education Records" under FERPA. I understand that this means the records may be disclosed without my consent to the extent authorized by FERPA.

• I understand that Bates College Health Services may decline to disclose health records if it is determined by the provider that such disclosure would be detrimental to my health. I understand that I will be notified if any such records are withheld.

This authorization will expire no later than 30 months from the date I have signed below, or if earlier, on

_____.

_____ _____

Signature of Student Date

I hereby acknowledge receipt/review of the records identified above.

_____ _____

Signature of Student Date