

Authorization for Disclosure 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 disclosure of my health information as follows *(please select the authorized disclosures below)*:

I. Disclosure from Bates Health Services to Student/Parent/Guardian

___ I authorize Bates Health Services to disclose 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. Disclosures between Bates Health Services and a Provider/Other Third Party

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

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

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

III. Medical Records to be Disclosed

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

- ___ My complete clinical record
- ___ My clinical records for the dates ___/___/___ to ___/___/___
- ___ Any and all information relating to my care and treatment maintained by the disclosing party identified above
- ___ The following specific records or information: _____

I specifically intend this authorization to include the disclosure of (check all that apply):

- ___ **Mental and behavioral health records and information maintained by licensed mental health facilities, programs or agencies, or related to mental health services provided by licensed mental health professionals.** I understand that I have the right to review any mental and behavioral health records maintained by licensed mental health facilities, programs, or agencies at any reasonable time before deciding to authorize their disclosure on this form. Bates Health Services is not a licensed mental health facility, program, or agency.
- ___ **Substance use disorder program records and information subject to 42 C.F.R. Part 2.**

____ **HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and ARC (AIDS-Related Complex) records and information.** I understand that authorizing the disclosure of such records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.

I (____DO ____ DO NOT) want to review this information before it is disclosed. I understand that reviews must be supervised.

IV. **Important Information about your Rights.** By signing below, I acknowledge that I have read this authorization and understand that:

- *Unless I strike out any of the following*, I intend this authorization to include (i) disclosure of records and information the disclosing party has received from other healthcare providers or facilities, and (ii) subsequent disclosures of information within the scope of this authorization (i.e., the disclosing and recipient parties of my health care information identified above are authorized to have continuing communications concerning the health care information authorized to be disclosed by this form, and may exchange information covered by this authorization that was created or related to clinical encounters occurring after the date of my signature below).
- 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) unless authorized by law. I understand that I may refuse authorization to disclose all or some health care information, but that refusal may 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 (except to the extent that Bates Health Services or any other entity has already acted in reliance on it prior to receiving the notice of revocation). Any such revocation could be the basis for a denial of health benefits or other insurance coverage or benefits.
- This authorization will be retained as part of my healthcare information and I am entitled to a copy of this authorization form upon request.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity and that, as a result, the information may no longer be protected by federal or state law.
- 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.

This authorization will expire no later than 12 months from the date I have signed below, or if earlier, upon the following date or event _____.

Signature of Student/Authorized Representative

Date

If signed by Authorized Representative:

Authorized Representative's Legal Authority:

Printed Name of Authorized Representative

Check the applicable box:

☐ Parent of minor ☐ Legal guardian ☐ Health care surrogate

☐ Healthcare power of attorney agent ☐ Other: _____

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

Signature of Student/Above-Named Authorized Representative

Date

If this disclosure includes substance use disorder program records subject to 42 C.F.R Part 2:

42 C.F.R. Part 2 prohibits unauthorized use or disclosure of these records.