ROBERTS WESLEYAN COLLEGE	NORTHEASTERN Seminary

HEALTH CENTER

2301 Westside Drive ~ Rochester, NY 14624
Phone: 585.594.6360 Fax: 585.594.6920

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations, Roberts Wesleyan College may not use or disclose your protected health information except as provided in our Notice of Privacy without your authorization. In order to share your Protected Heath Information (PHI) with others you stipulate; please complete, sign, date, and return the authorization to the Health Center.

Name: ____ Phone Number ______________

Birthdate: _____ /_____/ _____ Address: ____

Student ID#______________ ____

I hereby authorize: ___ Roberts Wesleyan College Health Center
___ Other (Please specify) ____

(Address or phone/ fax number) ____

To release to: ___ Roberts Wesleyan College Health Center
___ Other (Please specify) ____

(Address or phone/fax number) ____

The following Protected Health Information: *(place a ✓ next to all items to be released)*

___ Immunization Record ___ Health History ___ Recent Physical ___ Other (Please specify)

____

For the specific purpose of: (describe in detail)

____

____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____ (one year maximum)
This authorization will expire at the end of the above period.

I acknowledge that I have the right to inspect a copy of the Notice of Privacy Practices, to restrict what is disclosed, to revoke this authorization at any time in writing by sending written notification to the Health Center personnel at Roberts Wesleyan College. I understand that the revocation of this authorization is not effective if the Health Center has used the authorization for disclosure of PHI before receiving my written revocation notice. I understand that any PHI disclosed as a result of this authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that I may request a copy of this authorization.

____ ______________________

Signature of Student or Student's Authorized Representative *Date*