Spelman College
DEPARTMENT OF STUDENT HEALTH SERVICES
PHONE: 404-270-5249 FAX: 404-270-5257

Fax [ ] Mail [ ] Pick-Up [ ]

Authorization to Release/Obtain Protected Health Information

RE: _____ _____ _____ _____
Patient Name (please print) | Date of Birth | Social Security Number | Year of Graduation

1. I Authorize:

_____
Name of sending person or organization

_____
Street Address

_____
City State Zip

_____
Fax # Phone #

2. To Release Information To:

_____
Name of receiving person or organization

_____
Street Address

_____
City State Zip

_____
Fax # Phone #

Reason for Disclosure of Information:
[ ] Consultation / Referral [ ] Insurance Claim [ ] Attorney Inquiry

I authorize the disclosure of my health information (Protected Health Information) noted below:
(Please note: the applicable processing fees for the Student Health Services Department which must be paid at time of request)

Currently enrolled Students

[ ] Immunization Records only ($5 fee)
[ ] Entire **medical record** ($30 fee)
[ ] Lab Report(s): Date(s) _____
[ ] X-ray report(s): Date(s) _____
[ ] Gynecological, including pap smears _____
[ ] Other _____ _

Alumni and Archived Records

[ ] **Archived** Immunization Records Only ($40 fee)
[ ] **Archived** Entire **medical record** ($65 fee)
[ ] X-ray report(s): Date(s) _____
[ ] Gynecological, including pap smears _____
[ ] Other _____

[ ] Confidential Communications: Start Date: _____ End Date: _____ **(Both dates are required)**

- I understand that I may inspect my records and that a reasonable fee may be charged for the duplication or transmission of this authorization which I will be advised of prior to the request being processed.
- I understand that I (or the person/organization authorized to act on my behalf) am entitled to receive a copy of this authorization.
- I understand that Protected Health Information disclosed to others is no longer protected by the Student Health Services Department of Spelman College or the Health Insurance Portability and Accountability Act of 1996.
- I am aware of the consequences that may occur as a result of my signing this authorization request or my denial to do so.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. Send written revocation notice to: Spelman College, Student Health Services Department/MacVicar Hall ~ Campus Box 1683, Atlanta, GA 30314.
- Unless otherwise specified below, I understand that this authorization shall expire 60 days from the request date. I request that this authorization expire on _____ (specify date of event).

By signing below, you are hereby authorizing the Student Health Services Department of Spelman College to request or release the information specified on this form.

_____ _____ _____
Patient Signature | Daytime Phone Number | Date

FOR OFFICE USE ONLY

Date Copy Requested: _____ Date Copy Mailed, Faxed, or Picked Up: _____ Fees Paid: Yes _____ No _____

Authorization Added to the Patient's Medical Record on _____