AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Florida Southern College Student Health Center to release confidential health information, which may include diagnostic results, immunization record, school physical, record of clinic visits, information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human Immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment and treatment for substance abuse.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying the Florida Southern Student Health Center in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being processed.
3. I understand that the information disclosed may be subject to redisclosure and may no longer be protected by the federal privacy regulations.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will.
5. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: _____. If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.
6. I understand the matters discussed in this form. I release Florida Southern College Student Health Center and provider from all legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Full Name: _____ **Student ID**: _____

Address: _____ **Date of Birth**: _____

_____ **Phone Number**: _____

Covering the period of _____ to _____

Purpose of disclosure

Personal ____ Continued Care ____ Other: _____

Information to be disclosed: (please initial all that apply)

____ The front of the medical record which includes: student's name, address, Social Security number, phone number, school physical, and immunizations.

____ Laboratory results ____ Radiology results ____ Consult report ____ Office visits ____ Complete chart

Disclose Information to:

____ Myself

1. Name: _____ Phone/Fax Number: _____
   Address: _____
2. Name: _____ Phone/Fax Number: _____
   Address: _____

I am the patient/student and I understand and agree to the provisions of this form/authorization.

_____ _____ _____

Date of authorization Patient/Student Signature (or legally authorized representative) SSN