HILLSDALE COLLEGE HEALTH AND WELLNESS CENTER
Authorization for Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 and its corresponding regulations, as amended ("HIPAA"), the Hillsdale College Health and Wellness Center may not use or disclose your protected health information without your authorization except as permitted by law and as provided in the Notice of Privacy Practices. Your completion of this authorization form means that you are giving permission for the uses and disclosures of the protected health information ("PHI") described below. Please review and complete this form carefully and completely.

I. Information About the Use or Disclosure

I hereby authorize the Hillsdale College Health and Wellness Center to use or disclose my PHI to _____(persons / organizations authorized to receive the information) at _____ _____ (address) as described below. I understand that this authorization is voluntary and that I may refuse to sign this authorization.

- Name:_____
- Specific description of information to be used or disclosed (including applicable date(s)):_____ _____ _____ _____ _____

- Specific purpose of the use or disclosure (check one):

____ At the request of the individual

____ Other (please elaborate) _____ _____ _____ _____

- This authorization will expire on (date or event):_____ _____

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Hillsdale College Health and Wellness Center in writing at 33 East College Street, Hillsdale, Michigan 49242, but the revocation will not have any effect on any actions that the Hillsdale College Health and Wellness Center took in reliance on my authorization prior to receiving the revocation. Please see the Notice of Privacy Practices for the Hillsdale College Health and Wellness Center for further information.

- I may see and copy the information described in this form if I ask for it.

- I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on signing this authorization except for (1) conducting research-related treatment; (2) to obtain information in connection with eligibility or enrollment in a health plan or for the health plan's underwriting or risk rating determinations (but not for the use or disclosure of psychotherapy notes); or (3) solely to create protected health information for disclosure to a third party.

- The information that is used or disclosed pursuant to this authorization may be redisclosed by the recipient. Redisclosed information may no longer be protected by the HIPAA privacy standards.

_____ _____

Printed Name Date

_____

Signature

_____

_____

(if signed by personal representative of the individual, describe your authority to act for the individual)

FOR INTERNAL USE

Witness of Execution of Authorization: _____

Date: _____