



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (rev Apr2010)

I. General Information Regarding This Authorization

This Authorization permits Baird Health & Counseling Center to use or to disclose your Protected Health information.

Right to Revoke: You have the right to revoke this Authorization by providing the health center with written notice of revocation.

Redisclosure: You understand that when your protected health information is disclosed pursuant to this authorization it may be subject to redisclosure by the individual or receiving entity.

Provision of Service: The health center cannot require you to sign this Authorization as a condition to the provision of services.

II. Description of Health Information to be disclosed

I hereby authorize the Health Service or any of its staff to use or to disclose my Health Information described as follows:

Medical Record Immunizations Only Counseling Record Other: _____ Specific Dates: From _____ to _____

III. Individual or Entity Authorized to Receive the Health Information

<input type="checkbox"/> FROM or <input type="checkbox"/> TO Baird Health & Counseling Center Colby-Sawyer College 541 Main Street, New London, NH 03257 Tel. 603.526.3621 Fax 603.526.3453	<input type="checkbox"/> FROM or <input type="checkbox"/> TO Name: _____ Address: _____ Phone: _____ Fax: _____
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IV. Reason For Disclosure: The purpose of this requested use or disclosure is: _____

V. Expiration

This Authorization will expire one year after its effective date unless revoked OR unless date of expiration specified: ____/____/____
MM/DD/YYYY

VI. Release of Sensitive Information

Alcohol / Drugs:	<input type="checkbox"/> I Do	<input type="checkbox"/> I Do NOT	authorize the use or disclosure of drug and alcohol ¹ abuse related records.
Counseling / Psych. Care:	<input type="checkbox"/> I Do	<input type="checkbox"/> I Do NOT	authorize the use or disclosure of these treatment records.
STD Testing:	<input type="checkbox"/> I Do	<input type="checkbox"/> I Do NOT	authorize the use or disclosure of these testing and treatment records.
HIV Status:	<input type="checkbox"/> I Do	<input type="checkbox"/> I Do NOT	authorize the use or disclosure of these testing and treatment records.
Genetic Testing Results:	<input type="checkbox"/> I Do	<input type="checkbox"/> I Do NOT	authorize the use or disclosure of these test results.

VII. Authorization of Release of Information

MAIL FAX E-MAIL PICK-UP

_____ SIGNATURE	_____/_____/_____ DATE OF BIRTH: MM/DD/YEAR	_____ YEAR OF GRADUATION
_____ PRINT NAME	_____/_____/_____ DATE: MM/DD/YEAR	_____ WITNESSED BY:

Note¹: Protected under federal regulation (42 CFR Part 2)

BHCC Use Only

DATE REC'D: ____/____/____ DATE SENT: ____/____/____ INITIAL: _____ MAIL FAX E-MAIL PICK-UP