AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The individual or organization identified below as the Recipient ("Recipient") requested Nursing Practice Corporation, a Michigan non-profit corporation doing business as Campus Health Center (the "Center"), to collect and/or disclose certain Protected Health Information, as defined by HIPAA ("PHI"), about the Patient listed below. By law, we are required to obtain Patient's authorization prior to making such a disclosure.

I hereby ☐ AUTHORIZE ☐ DO NOT AUTHORIZE the Center to disclose to:

Name of Recipient of PHI: _____ Fax: _____

Address: _____ Phone: _____
Street City State Zip Code

the following PHI:

- ☐ Confirmation of immunization record submission
- ☐ Results of Sickle Cell Trait test
- ☐ Results of Tuberculosis (TB) Testing
- ☐ Other: _____

Information about the Patient:

Patient Name: _____ DOB: _____
First Middle Initial Last MM / DD / YY

Phone: _____ Student ID: _____

Address: _____
Street City State Zip Code

***If Other Than the Patient Listed Above,* Information about the Person or Organization <u>Authorizing</u> the Release of PHI:**

Name: _____ Phone: _____
First Middle Initial Last

Relationship to Patient: _____ ☐ Documents of Relationship to Patient Attached

Address: _____
Street City State Zip Code

I understand that authorizing the disclosure of PHI to the Recipient is voluntary and that it covers multiple requests for and disclosures of such information, and that this authorization authorizes the Center to respond to such requests. I also understand that I may refuse to provide authorization for disclosure of PHI to the Recipient, and the Center may not condition treatment, payment for services, or eligibility for benefits on whether I sign this Authorization. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the Recipient and the information may not be protected by federal or state privacy rules. I further understand that I may request a copy of this signed Authorization.

This Authorization may be revoked at any time in writing at any time by sending or delivering a signed revocation to the address listed above. The revocation is effective upon receipt but will have no impact on uses or disclosures of PHI made while the Authorization was valid. If not previously revoked, this Authorization shall expire on the date listed above or, if no date is given, this Authorization will be valid for 180 days only. For additional information on uses and disclosures of PHI by the Center please refer to our Notice of Privacy Practices.

I ACKNOWLEDGE AND AGREE THAT IF I REFUSE TO PROVIDE THIS AUTHORIZATION OR REVOKE THIS AUTHORIZATION PRIOR TO THE CENTER'S DISCLOSURE OF THE PHI REQUIRED OR REQUESTED BY THE RECIPIENT, THE CENTER IS NOT RESPONSIBLE FOR ANY CONSEQUENCES OF FAILURE TO DISCLOSE ANY INFORMATION TO THE RECIPIENT AND IS NOT RESPONSIBLE TO NOTIFY ME OR ANY THIRD PARTY OF ANY SUCH CONSEQUENCES. I AGREE THAT I WILL NOT HOLD THE CENTER AND/OR ITS AGENTS RESPONSIBLE FOR ANY LIABILITY, LOSS, DAMAGE OR EXPENSE CAUSED OR INCURRED AS A RESULT OF MY REFUSAL TO PROVIDE THIS AUTHORIZATION, REVOKING THIS AUTHORIZATION, AND/OR IN CONNECTION WITH ANY DISCLOSURE OF PHI PURSUANT TO THIS AUTHORIZATION.

Patient Signature: _____ Date: _____

Patient's Authorized Representative's Signature: _____ Date: _____

For Office Use Only:

If Patient is unable to sign, secure signature of Next of Kin or Legal Agent/Guardian and indicate reason why Patient is unable to sign:

- ☐ Minor
- ☐ Incompetent
- ☐ Disoriented
- ☐ Medically Unstable

Processor's Initial's _____ Date Sent Out: _____/_____/_____