

Spelman College
Department of Student Health Services
MacVicar Hall
350 Spelman Lane SW, Box 1683
Atlanta, GA 30313
(404) 270-5249
(404 270-5257 (Fax))

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Spelman College Student Health Services is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I specifically authorize Spelman College Student Health Services to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization by putting this information in writing to Spelman College Student Health Services.

Description of the information to be used or disclosed (*check all that apply*):

The patient's entire medical record (**NOTE:** This requires an explanation why the entire record may be disclosed and \$25.00 for copy and processing fee)

Medical Data/Information as related to:

X-Rays (specify):

Laboratory Tests:

Immunizations ((5.00 processing fee required):

Gynecological, including pap smears

Other:

Patient's Name requesting information: _____

Address: _____ City/State/Zip _____

Telephone (Home) _____

(Work/Cell) _____

Last four digits of SSN#: _____ Year of Enrollment _____

Date of Birth: _____ Year of Graduation _____

Graduation _____

Purpose(s) of the information: _____

This authorization permits Spelman College Student Health Services to send the protected health information **ONLY** to this address or fax number:

Any other address or fax number is not permitted by this authorization. This authorization shall expire on _____. After this date Spelman College Student Health Services can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

Patient's Signature

Date

FOR OFFICE USE ONLY

Date Copy Requested: _____ Date Copy Mailed or Faxed (circle one): _____

Fees Paid: Yes _____ No _____ Authorization added to the patient's medical record on _____.