WASHIN TON COLLEGE

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION TO WASHINGTON COLLEGE

Student ID

To

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§ 4-301 – 4-307.

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize to release the protected health information of:

N

PHONE: DATE OF BIRTH:

ADDRESS

The information is to be released to:

WASHINGTON COLLEGE

[redacted]

300 Washington Avenue

Chestertown, MD 21620

Ph: 410.778.7261 / Fax: 410.810.7101

[redacted]

The purpose for such disclosure is:

_ t (only patient may check) _ Payment/Insurance
_ Other _ Employment/Internship

This authorization will expire one year from the date it is signed unless a shorter time is indicated here:

I understand:

- This authorization is voluntary.
- My payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this on form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This e may be revok the ext has
  been f To revoke the I must ce I
- on has been disclosed ure of the
  i longer be protected by th regulations
  .

Patient or Personal Representative's

If signature is other than patient, provide proof of your authority, and explain your authority to act for the patient:

Witness Date

Proof of ID