Counseling Center
Dartmouth College
7 Rope Ferry Road, Hanover, New Hampshire ♦ Phone: (603) 646-9442 ♦ Fax: (603) 646-9506

Authorization for Disclosure of Protected Health Information (PHI)

Name: _____ Date of Birth: _____ Phone Number: _____

Net ID: _____

The purpose of this disclosure is: ❑ Continuity of Care ❑ Information Sharing ❑ Personal Use

❑ Time Away for Medical Reasons ❑ Other: _____

I hereby authorize the Counseling Center to disclose, by any acceptable means, including fax, phone, or email, my Protected Health Information (PHI) as specified below:

❑ Counseling treatment records
❑ Medication management records
❑ Information needed to coordinate academic consideration
❑ Information needed to coordinate time away & return for medical reasons
❑ Nutrition Wellness Team coordination of care
❑ OTHER: _____
_____
_____

To the following persons or class of persons:

❑ Academic Skills Center (ASC)
❑ Deans office
❑ Follow-up Provider
❑ Student Accessibility Services (SAS)
❑ Time Away Director's office (TAMR office)
❑ Treatment Provider *(fill in name & address below*)*
❑ Parents/Other Family *(fill in name & address below*)*
❑ OTHER: _____

*RECIPIENT'S NAME: _____ PHONE: _____ FAX: _____

*DELIVERY ADDRESS (EMAIL OR MAIL): _____

*****Internet communication isn't always secure. By requesting records to be released via email I acknowledge the risk.***

This Authorization for Disclosure of Protected Health Information shall be <u>effective for a period of one year from the date signed below</u>, unless earlier revoked or alternate date is specified here: ___ / ___ / _____.

By signing this Authorization for Disclosure of Protected Health Information, I understand that:

a. A photocopy, fax, or electronic copy of this authorization shall be as valid as the original.
b. I am not required to sign this authorization as a condition of the receipt of services from the Counseling Center.
c. Once information is disclosed pursuant to this Authorization it may no longer be protected by Federal and State regulations and may be re-disclosed by the recipient.
d. This Authorization may be revoked at any time by writing to the address above. The revocation will be effective upon receipt by the Counseling Center except with respect to disclosures made prior to receipt and in reliance upon this Authorization.
e. Information disclosed to Dartmouth employees pursuant to this authorization would be an "educational record" covered by the Family Educations Rights and Privacy Act ("FERPA").

_____ _____
Signature of Patient or Legal Representative **Date Signed**

_____ _____
Print Patient Name Print Name of Legal Representative and Relationship to the Patient