



# 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: \_\_\_\_\_

Graduation Year: \_\_\_\_\_

**I hereby authorize the Counseling Center or any of its staff to disclose, by any acceptable means, including fax, phone, or email, my Protected Health Information as specified below:**

- |  |  |
|--|--|
| <input type="checkbox"/> Counseling treatment records                            | <input type="checkbox"/> Nutrition treatment records                         |
| <input type="checkbox"/> Medication management records                           | <input type="checkbox"/> Information needed to coordinate community referral |
| <input type="checkbox"/> Information needed to coordinate academic consideration | <input type="checkbox"/> OTHER: _____  |
| <input type="checkbox"/> Eating Disorder Team coordination of care               | _____  |

### To the following persons or class of persons:

- |   |   |
|---|---|
| <input type="checkbox"/> Academic Skills Center (ASC) Staff                     | <input type="checkbox"/> ORL Staff  |
| <input type="checkbox"/> Deans Office Staff                                     | <input type="checkbox"/> Student Accessibility Services (SAS) Staff                       |
| <input type="checkbox"/> Follow-up Provider                                     | <input type="checkbox"/> Parents/Other Family ( <i>fill in name &amp; address below</i> ) |
| <input type="checkbox"/> Office of Community Standards and Accountability Staff | <input type="checkbox"/> Treatment Provider ( <i>fill in name &amp; address below</i> )   |
| <input type="checkbox"/> Community Referral Therapist                           | <input type="checkbox"/> OTHER: _____   |
| <input type="checkbox"/> Office of Financial Aid                                | _____   |

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.*

**The purpose of this disclosure is:**  Continuity of Care  Information Sharing  Academic Support  Other:

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

- This Authorization for Disclosure of Protected Health Information shall be effective for a period of one year from the date signed, unless earlier revoked or alternate date is specified here: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- A photocopy or fax of this authorization shall be as valid as the original.
- I am not required to sign this authorization as a condition of the receipt of services from the Counseling Center.
- 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.
- 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.
- Information disclosed to Dartmouth employees pursuant to this authorization would be an "educational record" covered by the Family Educational 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