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:

- ❑ Counseling treatment records
- ❑ Medication management records
- ❑ Information needed to coordinate academic consideration
- ❑ Eating Disorder Team coordination of care
- ❑ Nutrition treatment records
- ❑ Information needed to coordinate community referral
- ❑ OTHER: _____ _____

To the following persons or class of persons:

- ❑ Academic Skills Center (ASC) Staff
- ❑ Deans Office Staff
- ❑ Follow-up Provider
- ❑ Office of Judicial Affairs Staff
- ❑ Community Referral Therapist
- ❑ Office of Financial Aid
- ❑ ORL Staff
- ❑ Student Accessibility Services (SAS) Staff
- ❑ Parents/Other Family *(fill in name & address below)*
- ❑ Treatment Provider *(fill in name & address below)*
- ❑ OTHER: _____ _____

RECIPIENT'S NAME: _____ PHONE: _____

RECIPIENT'S ADDRESS: _____ FAX:_____

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

If applicable, please INITIAL the appropriate blank in the following statement:

a. Alcohol or Drug Treatment Records: **I DO ____ / I DO NOT ____** authorize the disclosure of drug or alcohol abuse treatment records. I understand that these records are protected under federal regulations (42 CFR Part 2). I understand that I have the right to refuse to release this information. [Send 42 CFR Part 2 advisory with record.]

b. HIV Status: **I DO ____ / I DO NOT ____** authorize the release of HIV test results for the purpose set forth.

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

a. 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: _____ /_____ / _____

b. A photocopy or fax of this authorization shall be as valid as the original.

c. I am not required to sign this authorization as a condition of the receipt of services from the Counseling Center.

d. 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.

e. 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.

f. 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