Trinity College Health Center with Care Provided by
Hartford HealthCare, Campus Care
300 Summit Street
Hartford, CT 06106-3100
p) 860.297.2018
f) 860.297.2020
e) healthcenter@trincoll.edu

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, _____ (DOB _____/_____/_____) authorize

To: ☐ Trinity College Health Center

☐ From:_____
Address:_____
Phone:_____
Fax:_____
Email:_____

From: ☐ Trinity College Health Center

☐To: _____
Address:_____
Phone:_____
Fax:_____
Email*:_____

**Emails generated from the Health Center will be secure emails via Hartford Healthcare and all replies to the secure email will remain secure.*

I request that the information to be used or disclosed consist of the following (*if this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes):*

CHECK ALL THAT APPLY:

☐ Complete Medical Record ☐ Immunizations ☐Other (Specify):_____

I also specifically authorize that any sensitive information regarding HIV/AIDS, substance abuse (alcoholism or drug abuse) and/or mental health may be used by or disclosed to the above referenced recipients.
It is my understanding that the information to be used or disclosed will be used for the following purposes

CHECK ALL THAT APPLY:

☐ At the request of the individual ☐ Additional Medical Care ☐ Legal Investigation or Action
☐ Insurance Eligibility/Benefits ☐ Change of Provider ☐ Other (Specify): _____

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand that I may be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form and that Student Health Services may not condition my treatment, payment, or enrollment/eligibility on my decision to sign this form. I understand that I may revoke this Authorization by notifying Student Health Services in writing of my revocation. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This Authorization is valid for one year from date signed unless otherwise specified. I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes

_____ _____
Signature—Patient or Legal Guardian **Print Name**

_____ _____ _____
Student ID# **Date** **Contact Phone Number**

Partnered with Hartford HealthCare