San José Evergreen Community College District
Student Health Services
Authorization to Release Medical and Mental Health Information

Authorization:

I give permission to the Student Health Services team (SHS) to use and release the below described information to:

Recipient Name: _____

Address: _____

Phone number: _____

Purpose:

The health information disclosed may only be used for the following purpose(s):

_____

Information to be Release:

Medical or mental health information (please describe):

_____

Duration:
This authorization is valid immediately and will be valid until _____(give date). If I do not write in a date, it will expire twelve months from the date it was signed.

Conditions:
I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization. A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization. The information disclosed per the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

Cancellation:
I understand that I have a right to receive a copy of this authorization and to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Coordinator of Student Health Services (SJCC) or Director of Student Health & Wellness Services (EVC) and 3) is effective when it is received by SHS. A cancellation will not apply to actions already taken by SHS.

_____ _____ _____
Name Signature Date