BSC
BIRMINGHAM-SOUTHERN COLLEGE

Counseling & Health Services

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BIRMINGHAM-SOUTHERN COLLEGE
STUDENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the physician, nurse and any other health care personnel representing Birmingham-Southern College Health Services to release information regarding any injury or illness while enrolled as a student as BSC. This authorization may include information regarding my medical status, medical condition, prognosis, diagnosis and related personally identifiable health information.

I understand that my personal health information is protected by law under HIPAA (Health Information Portability and Accountability Act).

I understand that once this information is disclosed, it may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

I understand that this authorization is **voluntary** and may be revoked at any time by notifying the Assistant Director of Health Services in **writing**, but if I do, it will not have any affect on the actions that Birmingham-Southern College took in reliance on this authorization.

I understand that this authorization expires 5 years from the date of my signature below.

By completing this form, I authorize access to my protected health information to the following individual(s):

Name: _____ Name: _____

Relationship: Parent or legal Guardian or Spouse or Other *(please circle one)*

Student's Printed Name: _____

Student's Signature: _____

Student #: _____

Date: _____