1. I Authorize:

2. To Release Information To:

[ ] Consultation / Referral [ ] Insurance Claim [ ] Attorney Inquiry

(Please note: the applicable processing fees for the Student Health Services Department which must be paid at time of request)

[ ] Immunization Records only ($5 fee)

[ ] Entire ($30 fee)

[ ] Lab Report(s): Date(s) _____

[ ] X-ray report(s): Date(s) _____

[ ] Gynecological, including pap smears _____

[ ] Other _____

[ ] Immunization Records Only ($40 fee)

[ ] Entire ($65 fee)

[ ] X-ray report(s): Date(s) _____

[ ] Gynecological, including pap smears _____

[ ] Other _____

[ ] Confidential Communications: Start Date: _____ End Date: _____

I understand that I may inspect my records and that a reasonable fee may be charged for the duplication or transmission of this authorization which I will be advised of prior to the request being processed.

I understand that I (or the person/organization authorized to act on my behalf) am entitled to receive a copy of this authorization.

I understand that Protected Health Information disclosed to others is no longer protected by the Student Health Services Department of Spelman College or the Health Insurance Portability and Accountability Act of 1996.

I am aware of the consequences that may occur as a result of my signing this authorization request or my denial to do so.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. Send written revocation notice to: Spelman College, Student Health Services Department/MacVica1 (e1 (w(e1 (w(e) 5m) 4 (a)