



Health Information Use and Disclosure

Student Name: _____

Date of Birth: _____

This form authorizes the use and disclosure of individually identifiable health information to Massachusetts College of Liberal Arts Student Wellness Center.

The Student Wellness Center at Massachusetts College of Liberal Arts, which I consider my Primary Care Provider, utilizes an electronic medical record-keeping system (EMR) in affiliation with other health care providers. This system allows the Student Wellness Center and any health care providers to access different components of any patient’s “chart” and also provide up-to-date information to any provider who might see patients on an emergency basis and/or when the Student Wellness Center is closed. The Student Wellness Center also can promptly access test results as they are completed, bypassing clerical turnaround times. EMR is a welcome addition to the Student Wellness Center as they strive to provide efficient, comprehensive healthcare to our students.

1. I authorize the use and/or disclosure of the above-named individual’s health information as described below.
2. My health information will be shared only between the Student Wellness Center and other health care providers to facilitate continuity of care in the event I require treatment. It also will be available to affiliated specialists if I should require their services. This also will enable the Student Wellness Center to access my test results (laboratory tests, X-rays, cultures, etc) in a timely manner in order to expedite my care.
3. I understand that the information in my health record may include information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted disease. This information is confidential and solely for the Student Wellness Center and will in no way affect the student’s college standing. Medical information will not be released from the Student Wellness Center to the college without my consent unless the information gathered would lead the Student Wellness Center to suspect that I was either a danger to myself or other members for the college community.
4. I understand that this authorization is subject to revocation at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to any other health care provider’s medical records department. Unless otherwise revoked, this authorization will expire on June 15th each calendar year and I will need to sign a new authorization for the following school year

Student name (please print)
I accept this authorization

Student Signature

Date

Time

I decline this authorization

Student Signature

Date

Time