

**KEENE STATE COLLEGE
AUTHORIZATION FOR RELEASE OF INFORMATION**

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:	ID Number:
Address	Persons/Organizations receiving the information
Phone	

Specific description of information (including dates): _____

Section B: Must be completed for all authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ___/___/___ (MM/DD/YR).
Initials:___
2. I understand that I may revoke this authorization by sending a written request to Keene State College, Office of Human Resources Management, 229 Main Street, Keene, NH 03435-1604. You can obtain a form to revoke the authorization by calling the Office of Human Resources Management at 358-2877. Any revocation will not be effective for any actions we already have taken.
Initials:___
3. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials:___

Signature of patient or patient's representative

Date

(Form MUST BE completed before signing)

Printed Name of Patient

Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION