HIPAA Release

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize NHTI Health Services to disclose/discuss my protected health information with _____ (name of parent/guardian/spouse/other – please circle).

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Student signature Date

_____ _____

Printed name of student Student ID

Updated 12.2.2020