Office of Accessibility Authorization for Disclosure of Protected Health Information

Name:	First	Middle
Date of Birth:		
Student Status (check one):pr	ospective current tr	ansier
Local phone: ()	Cell phone:	()
Address (street, city, state and zip	code):	
Winthrop E-Mail address:		@mailbox.winthrop.edu
Alternate E-mail address:		
Records Released From (ie Health	,	
Name:		
		Zip:
		<u>.</u>
	gnosis and accommodation to of Accessibility, Winthro	
questions regarding this Notice answered clearinghouses must follow the federal p health information (PHI) does not fall ir federal privacy standards therefore, all authorization. I understand that I may ca	I to my satisfaction. I understand privacy standards. If an individuate one of these categories, this lowing for the possibility of an uncel this authorization but that a	ctices (as indicated) and have had all of my and that only health care providers, plans, and dual or organization receiving my protected authorization ceases to be protected by the my PHI being redisclosed without further my withdrawal is only effective to the extent rm. In order to withdraw this authorization
This authorization will remain in effect effective for an additional time period. V		unless you specify this authorization will be evoke this request.
I have had an opportunity to review and authorization, I am confirming that it acc		nthorization form. By signing this
Patient/Client/Student Signature		Date