Trinity College Health Center with Care Provided by
Hartford HealthCare, Campus Care
300 Summit Street
Hartford, CT 06106-3100
p) 860.297.2018
f) 860.297.2020
e) healthcenter@trincoll.edu

I, _____ (DOB _____/_____/_____) authorize:

To: ☐ Trinity College Health Center

From: ☐ Trinity College Health Center

☐ From: _____
Address: _____
Phone: _____
Fax: _____
Email: _____

☐To: _____
Address: _____
Phone: _____
Fax: _____
Email*: _____

**Emails generated from the Health Center will be secure emails via Hartford Healthcare and all replies to the secure email will remain secure.*

I request and authorize Trinity College to disclose the following information about me (or my child/ward) (*if this is an authorization for the use or disclosure of psychotherapy notes, it may not be combined with an authorization for the use and disclosure of any other type of health information except other psychotherapy notes):*

CHECK ALL THAT APPLY:
☐ Complete Medical Record ☐ Immunizations ☐Other (Specify):_____

I also specifically consent to the disclosure of sensitive personal health information about me (or my child/ward) to the above referenced recipient(s) relating to HIV/AIDS, substance abuse (alcoholism or drug abuse) and/or mental health assessment or treatment.

It is my understanding that the information to be used or disclosed will be used for the following purposes:

CHECK ALL THAT APPLY:
☐ At the request of the individual ☐ Additional Medical Care ☐ Legal Investigation or Action
☐ Insurance Eligibility/Benefits ☐ Change of Provider ☐ Other (Specify): _____

I understand that if an authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, once the information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy standards. However, other state or federal law may prohibit the recipient from disclosing specially protected information about you, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information. It is your responsibility to be informed about the applicability of such protections.

INDIVIDUAL'S RIGHTS RELATING TO THIS AUTHORIZATON:
I understand that I am under no obligation to sign this form and that the Health Center may not condition my treatment, payment, or enrollment/eligibility on my decision to sign this form. I understand that I may revoke this Authorization by notifying the Health Center in writing of my revocation. I understand that my revocation will not be effective as to disclosures of personal health information that was disclosed to the person(s) and or organization(s) listed above prior to revocation of this Authorization.

EXPIRATION DATE: This Authorization is valid for one year from date signed, unless otherwise specified. By my signature below, I affirm that I have had an opportunity to review and seek advice regarding the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ _____
Signature/Student or Parent/Legal Guardian **Print Name**

_____ _____ _____
Student ID# **Date** **Contact Phone Number**

Partnered with Hartford HealthCare