William Paterson University
Clinical Student Request and Authorization to Release Records and/or Information

This form when completed and signed by you authorizes the Counseling, Health and Wellness Center, the Directors & Clinical Instructors of the Nursing Department, and the Directors & Clinical Instructors of the Communication Disorders Program to release protected information from your clinical record to the person or agency you designate.

I, ____, authorize the Counseling, Health and
(print name of student)

Wellness Center clinical and administrative staff, the Directors & Clinical Instructors of the Nursing Department, and the Directors & Clinical Instructors of the Communication Disorders Program to release information to one another regarding my clinical physical and any relevant information related to participation in the nursing and communication disorders programs at William Paterson University.

The records are to be discussed verbally, via fax, or via email for the purpose of coordination of care.

This authorization shall remain in effect for one year from the date signed below (unless otherwise indicated).

I understand that I have the right to revoke this authorization in writing, at any time by sending or delivering such written notification to the Counseling, Health and Wellness Center. However, my revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this 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 the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

________________________________ ____________________
Student ID# Date of Birth

____ _______________
Signature of student (*parent if minor)* Date

Revised 1/11/15