HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AUTHORIZATION FORM FOR HEALTH INFORMATION TO BE DISCLOSED TO DELGADO COMMUNITY COLLEGE ("DELGADO")

The status of the person whose health information is authorized by disclosure (check one):

____Student
____Student-Applicant
____Employee
____Employee-Applicant

Name ____

(Please print the name of the person about whom the health information relates)

Address: ____

I. The following class of persons is authorized to disclose health information about to Delgado Community College: Any health plan, physician, health care professional hospital, laboratory, pharmacy, medical facility, or other health care provider that has provided or in payment, treatment or services to about or on my behalf.

2. The following person(s) may receive disclosure of protected health information about me:

Shannon Skena, MLT Program Director, Delgado Community College /City. Park Campus /Allied Health

Delgado Community College
615 City Park Ave.
New Orleans, LA 70119

3. The specific information to be disclosed is:

Alcohol or drug test results, substance abuse counseling or rehabilitation results, medical examination results and screening results (e.g., Hepatitis, B, Varicella, Rubella Titer screening) including and/or health information as follows:

____

4. This authorization includes my consent to the release of information about:

Alcohol/Drug/Substance Abuse ____ (initials)
HIV/Aids _____(initials)
Mental Health _____ (initials)

5. The purpose for/intended use of the information at my request.

6. I understand that the information used or disclosed may be disclosed by the recipient, and that such disclosure may not be protected by federal privacy regulations.

7. I may revoke this authorization by notifying Shannon Skena in writing of my desire to revoke. I understand that any revocation will not be until the revocation has been received, and that any action already taken on this authorization cannot be reversed. I understand that if it is necessary to obtain or maintain insurance coverage, the insurer may have the right to contest a claim under the resulting policy, or the policy itself based on my revocation.

8. My authorization as provided by this document is voluntary. I understand that if I do not complete and sign the authorization to disclose the information I may render myself ineligible to enroll or continue in Delgado's School of Nursing or Allied Health program(s), or ineligible for employment or continued employment with Delgado, as applicable.

9. I understand that a covered entity to whom this authorization is furnished may not condition its treatment, payment, enrollment or eligibility for benefits on whether or not I sign the authorization.

10. This authorization expires (check one):

_X___if a Student or Student-Applicant, upon completion of program and/or graduation, as applicable, from Delgado's School of Nursing or Allied Health program(s); OR

___ if an Employee or Employee-applicant, when my application for employment or employment with Delgado terminates.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

____ ____________
Signature of person about whom the health information relates Date

____
Date of Birth OR Social Security No.

____ ____________
Signature of guardian or personal representative Date
(if applicable)

____
Basis to act for person about whom the health information relates

A copy of this completed, signed and dated form must be given to the person about whom the health information relates. Copies of this executed form may serve as authorization for the disclosures described above.