SHORTER UNIVERSITY
Transforming Lives through Christ

Check one:
Freshman __
Sophomore __
Junior __
Senior __

AUTHORIZATION for DISCLOSURE to DESIGNATED INDIVIDUALS

I, *(print)* _____, Student ID # _____have had the opportunity to read my HIPAA rights. I authorize Shorter University professional health care personnel to share certain information with (parent/guardian/sibling/spouse/other close relative).

1. (name) _____(relationship) _____, (telephone #) _____

and

2. (name) _____ (relationship) _____, (telephone #) _____

such as the nature, diagnosis, treatment and other medical information, when deemed pertinent by professional healthcare personnel in the event of an illness or injury while a student at Shorter University.

Additionally, I authorize Shorter University professional health care personnel to notify the above listed contact(s) in case I should have a medical emergency situation. I understand that I may formally change or revoke this authorization (as applicable). I understand that signing this form does not preclude my HIPAA disclosure consent given on the SHS's Health/Immunization form.

Emergency contact information must legally be maintained for all resident students. You may revoke authorization regarding release of medical information at any time by sending written notification to Student Health Services, Campus Box 37.

Student Signature:_____ Date: _____

Witness: _____ Date:_____

Authorization to release medical information revoked on: _____