Submit Form to: 6 W H S K D Q L H * D X W K L H U
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* D G V G H Q $ /

Authorization to Disclose Protected Health Information

6 W X G H Q W ¶ V 1 D P H	Birth Date	College/University	Policy Number
' H S H Q G H Q W (If applicable)	Date of Injury or First Treatment of Sickness	Condition	

*Student or Dependent who wants to allow others to call or receive communication on their behalf.

1. I authorize medical providers to discuss, disclose and/or release information identified in Paragraph 2, below, to the following individuals:

2.

% O D N H / H Z L V	$ W K O H W L F ' L U H F W R U
6 W H S K D Q L H * D X W K L H U Name (s) of authorized person(s)	$ G P L Q L V W U D W L Y H $ V V L V W D Q W $ W K O Relationship to the undersigned
PO Box 227 Address	Gadsden, AL 35902-0227 City, State, Zip

3. I hereby authorize medical providers, Inc. to discuss, disclose, and/or release information necessary to process or respond to eligibility inquiries, coverage/benefit inquiries, claims inquiries, appeals, and Explanation of Benefits about my student health insurance coverage with respect to the Injury or Sickness identified above. I further acknowledge that the information discussed, disclosed and/or released may include individually identifiable health information about me.

4. This authorization is being made at my request.

5. In signing this Authorization, I understand and acknowledge the following (initial in the space provided):

_____ I understand that this Authorization is voluntary and that I may refuse to sign it.

_____ I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

_____ I understand that I may revoke this Authorization at any time, by notifying GSCC Athletic in writing of my intent to revoke this Authorization, except to the extent that action has been taken in reliance on this authorization.

_____ I understand that, unless otherwise revoked, this Authorization will expire one year after the date of this permission.

_____ I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

I, the undersigned, do hereby affirm that I am the above-named student or dependent or an authorized legal representative. I have read and understand the above information.

_____ _____
Date Signature of Student or Dependent

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