APPENDIX 8

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 for disclosure (check one):
☒ Student ☐ Student-Applicant ☐ Employee ☐ Employee-Applicant

Name (please print): _____
(The name of the person about whom the health information relates)

Address: _____

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

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

   Name, position/title, Delgado college/school/division:

   Dr Jennifer Limon and RachelAnn Harb RVT Allied Health Veterinary Technology 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 medical screening results (*e.g.,* Hepatitis B, Varicella, Rubella Titer screening) including and/or other health information as follows: tetanus records, rabies preexposure vaccination records, and health insurance _____

4. This authorization includes my consent to the release of information about:
   Alcohol/Drug/Substance Abuse _____ (initial)

5. The purpose for/intended use of the information is 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 _Dr Jennifer Limon in writing of my desire to revoke. I understand that any revocation will not be effective until the revocation has been received, and that any action already taken in reliance on this authorization cannot be reversed. I understand that if authorization is needed 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 this authorization to disclose the medical information indicated 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_____

Printed name: _____

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.