PALOMAR COLLEGE
STUDENT HEALTH CENTERS

PALOMAR COLLEGE BEHAVIORAL HEALTH COUNSELING SERVICES

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

PATIENT/CLIENT

Name: ______________________________
ID#: ______________________________
Address: ______________________________
Telephone: ______________________________
Date of Birth: ______________________________

INDIVIDUAL/ORGANIZATION AUTHORIZED TO MAKE DISCLOSURE

Name: ______________________________
Palomar College Behavioral Health Counseling Services
1140 West Mission Road
San Marcos, CA 92069
Phone: 760-891-7531
Fax: 760-891-7831

INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL/ORGANIZATION

Name: ______________________________
Organization: ______________________________
Address: ______________________________
Telephone: ______________________________
Secured Fax #: ______________________________

THIS AUTHORIZATION PERMITS THE RELEASE OF THE FOLLOWING INFORMATION

- ○ Diagnosis
- ○ Treatment Plan
- ○ Progress
- ○ Treatment Summary
- ○ Dates of Treatment
- ○ Coordination of Care
- ○ Assessments/Evaluations__________________________
- ○ Other (Specify) ______________________________

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I authorize the release of the information described above for the following purpose(s): ____
____

The specific uses and limitations on the types of information to be released are as follows: ____
____

The specific uses and limitations on the use of the information by RECIPIENT are as follows: ____
____

- I understand that my health care and the payment for my health care will not be affected by signing this form.
- I understand that I may receive a copy of the information described on this form after I have signed the Authorization.
- I understand that I may revoke this Authorization at any time by notifying Palomar College Student Health Center in writing.
- I understand that this Authorization will expire on:_________________________

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

Signature____

Legal Representative________________________________
Relationship ______________________________________

Date ___________________________