Northwestern | QATAR

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name_____Date of Birth___/___/_____NUID #_____

I_____hereby authorize _____
(Student or Personal Representative)

to disclose specific health information from the records of the above named client to:

_____
(Provider/Agency)

_____
(Contact information (i.e., email, address, phone)

for the specific purpose(s) of: _____

Specific information to be disclosed:

- ☐Appointment verification
- ☐Treatment progress and recommendations
- ☐Concerns regarding student's wellbeing and/or safety for self or others
- ☐Any
- ☐Other: _____

Furthermore, I request and authorize _____ *(referring agency)* to release any information back to

_____in order to facilitate continuity of care:

I understand that this authorization will expire on the following date, event or condition: _____

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. If I revoke this authorization, I must do so in writing. Requests to revoke this authorization should be directed to the above named agency/provider.

I understand that any private health information disclosed under the authorization may no longer be protected by federal privacy regulations; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, or psychological or psychiatric conditions this disclosure will include that information. I also understand that I may refuse to sign this authorization.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of student)	*(Date)*	*(Witness)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

****

NOTE

_____ _____
(Date) *(Signature of Staff)*

P.O. Box 34102
Education City
Doha, Qatar

www.qatar.northwestern.edu