Hellenic College Holy Cross
Greek Orthodox School of Theology

Academic Services
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HIPAA Release

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act (HIPPA, 45 C.F.R. Parts 160 and 164)

Student: _____ **Date of Birth:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

Phone: _____ **Email:** _____

I, _____ (full name), give my permission to have my medical records released to Hellenic College Holy Cross (HCHC). The purpose of providing these documents is to determine interventions/accommodations that will provide services to me while I am a student at HCHC.

Name of Provider: _____

Address: _____

Phone: _____

Email: _____

Signature of Student: _____

Student` ID: _____ **Date:** _____

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My refusal will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

I understand that the College will not improperly disclose this information, as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that this information becomes part of a student's educational record. The information will be shared with individuals working at or with the Hellenic College Holy Cross for the purpose of providing safe and appropriate academic or psychological services.

Documents should be emailed or mailed to:

Danielle Brown
Coordinator of Academic Services
Hellenic College Holy Cross
50 Goddard Avenue
Brookline, MA 02445

For more information, please visit: www.hhs.gov/hipaa/