WOFFORD COLLEGE WELLNESS CENTER
AUTHORIZATION RELEASE STATEMENT

Patient Name____ Date of Birth ______________________________

SS# ____ Grad. Year ________________________________

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, PLEASE LIST BELOW.

Per my request, I hereby authorize Wofford College to communicate my medical information and/or billing information to the following individuals:

1. Name ____ Phone ____________________________

   Relationship ____ Alternate # _________________________

2. Name ____ Phone ____________________________

   Relationship ____ Alternate # _________________________

3. Name ____ Phone ____________________________

   Relationship ____ Alternate # _________________________

☐ Yes ☐ No I give permission to leave messages on my answering machine/voicemail. Phone ______________________
(I would like test results or appointment information left on my answering machine/voicemail)

☐ Yes ☐ No I give permission to call my place of employment. Phone ____________________________________

☐ Yes ☐ No I give permission to leave messages on my voicemail at work. Phone ____________________________

☐ Yes ☐ No I give permission to Wofford College to release information to my school or my employer regarding absences or immunizations.

RIGHTS OF PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the Privacy Officer or Administrator. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing. This authorization shall be in effect until revoked by the patient.

____ __________________________

Patient Signature Date

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Personal Representative Signature

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Description of Personal Representative's Authority