STUDENT ACKNOWLEDGMENTS

1. I understand that I can revoke this authorization at any time by submitting written revocation to the provider. However, uses and disclosures permitted while the authorization was in effect cannot be taken back.
2. I understand and acknowledge that the provision of healthcare to me is not conditioned on my execution of this authorization.
3. I understand that information disclosed per this authorization may be subject to redisclosure by the receipt and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

Student Signature: _____ Date: _____

If the student is a minor or unable to sign, please complete the following:

Name of Parent/Guardian: _____ Relationship to Student: _____

Signature of Parent/Guardian: _____ Date: _____