BOWDOIN COLLEGE HEALTH PLAN
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have read the Notice of Privacy Practices provided by the Bowdoin College Health Plans, which describes my privacy rights under the Health Insurance Portability and Accountability Act ("HIPAA"). I want to authorize the Plan or Plans designated below to use or disclose protected health information about me as described below.

[ ] Health Plan  [ ] Dental Plan  [ ] Health Care Reimbursement Plan

1. Description of information that may be used/disclosed:
________________________________________________________________________________________
________________________________________________________________________________________

2. The information may be used/disclosed for the following purposes:
________________________________________________________________________________________
________________________________________________________________________________________

3. Person(s) or class of persons authorized to use/disclose the information:
________________________________________________________________________________________
________________________________________________________________________________________

4. Person(s) or class of persons authorized to receive the information:
________________________________________________________________________________________
________________________________________________________________________________________

5. I understand that:
   a. If the person or entity that receives the information is not a health care provider or health plan covered by the HIPAA, the information described above may be redisclosed and no longer protected by HIPAA.
   b. I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect or obtain copies of my health information by contacting the Director of Human Resources.
   c. I must be provided with a copy of this signed authorization form.
   d. I am under no obligation to sign this form, however, the individual(s) and/or organization(s) listed above may in certain cases condition treatment, payment, enrollment in a health plan, or eligibility for health benefits on signing this authorization.
   e. Written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above already have made in reliance on this authorization.

This authorization expires ____________________________. To obtain information on how to withdraw your authorization or you may contact the Director of Human Resources.

_________________________________________ ______________________________
Signature of Covered Individual or Representative Date

________________________________________ _________________
Printed Name of Covered Individual Printed Name of Personal Representative Relationship to Covered Individual