MONTGOMERY COLLEGE

Authorization to Disclose Information

To assist in the administration of my claim(s) , I authorize ____________________

To share personal health information relating to my claim with

_________________________________(representative of Montgomery College)

I understand that information about my claim may include information about my health and that such information about my health may be related to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment.

I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

I may revoke this authorization in writing at any time.

This authorization is valid for the duration of my claim. I may request a copy of the authorization and a copy shall be as valid as the original.

________________________________ ______________

Employee Signature Date

________________________________ _______________

Printed Name M#