Student Optional Disclosure of Private Mental Health Information Form

Student ID: _____

Name: (please print) _____ (First)(Middle) (Last)

Date of Birth (MM/BD/YYYY) _____

As a student at Heartland Community College, I may authorize the disclosure of my private mental health information to the designated individual named below and understand that:

1. My chosen designated individual must be a parent, guardian, or other person, over the age of 18, designated by me to receive certain private mental health information.

2. My signature authorizes HCC to disclose my private mental information, to my designated individual only if a physician, clinical psychologist, or qualified examiner employed by HCC, makes a determination that I pose a clear danger to myself, or others, in order to protect me or another person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon myself, or another person.

3. This request will be in effect for the remainder of your enrollment at HCC.

   _____ I authorize the disclosure of my private mental health information to the following:

Name:

Address:

Phone Number:

_____ I do not authorize the disclosure of my private mental health information.

_____ _____
Student Signature Date

_____ _____
Student Records Signature Date

Entered _____ (date)

Once you have completed and signed this form, you can scan and email it to records@heartland.edu or walk the form to Student Records in room CCB 1600 of Heartland's Normal campus.