STUDENT NAME __________________________________________ SEMESTER REQUESTED ______

STUDENT CELL # _______________________________ STUDENT ID # ___________________

ON CAMPUS RESIDENCE ___________________ CURRENT # OF COMPLETED CREDITS ______

STUDENT EMAIL # ______________________________________________________________________

I request a medical parking exemption from Marist College for the following reason:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Attach appropriate signed medical documentation from a licensed medical practitioner. Unsigned
documentation will not be accepted.

Medical documentation will be reviewed by the Marist College medical staff before this application is
approved (Please see privacy release on the reverse side). Release form must be signed by the student before
the application will be processed.

You will be notified by the office of Safety and Security if this application is approved.

__________________________________________
STUDENT SIGNATURE __________________________ DATE __________________

HEALTH SERVICES APPROVAL ___________________ DATE __________________

SECURITY OFFICE APPROVAL ___________________ DATE __________________

NOTES: This request will NOT be approved without ALL signatures.

Do not bring your vehicle to campus until this request is approved. Unauthorized vehicles will be towed at the
owner’s expense and the owner will be subject to a one semester penalty for the semester after they earn 50
credits.

Parking space is limited and there is no guarantee that this request will be approved.

Any student with a parking exemption who receives a parking ticket will have the exemption revoked.
HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insure Portability and Accountability Act 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (“PHI”) described below:

2. Authorization for release of PHI covering the period of health care (check one)
   a. □ from (date) _____________________ - to (date) _____________________ OR
   b. □ all past, present, and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. □ my complete health records (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. □ my complete health record with the exception of the following information
      (check appropriate):
      □ Mental health records
      □ Communicable diseases (including HIV and AIDS)
      □ Alcohol/drug abuse treatment
      □ Others (please specify): ________________________________________________.

4. In addition to the authorization for release of my PHI described in paragraph 3a and 3b of this authorization, I authorize disclosure of information regarding my condition, treatment and prognosis to the following individual(s):

Marist College Health Services
Marist College Security
OR

Name: ________________________________________________

5. The medical information may be used by the persons I authorize to receive this information for the medical treatment or consolidation, billing or claims payment, or other purpose as I may direct.

6. This authorization shall be in force and effect for 2 years from the date signed by me.

7. I understand that I have rights to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that information used or disclosed pursuant to this authorization may disclosed by the recipient and may no longer be protected by federal or state law.

__________________________________________________
Date: ________________

Signature of Student/Patient