OHIO UNIVERSITY
Division of Student Affairs

Counseling and Psychological Services
Hudson Health Center 3rd Floor
1 Ohio University Drive
Athens, OH 45701-2979

T: 740-593-1616
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www.ohio.edu/counseling

office use only
Reviewed by:

Authorization for Release of Confidential Information

I, _____, date of birth _____, OUPID # _____,

hereby authorize staff members of Counseling and Psychological Services (refer to contact info above),

To ☐ release ☐ obtain ☐ release and obtain my protected health information to and or from:

Person: _____

Agency: _____

Address: _____

_____

Phone: _____ Fax:_____

The following information:

☐ Verification of Attendance
☐ Assessment and Diagnosis
☐ Psychiatric Treatment
☐ Medication Information
☐ Summary of Treatment
☐ Other: _____

This Authorization includes release of records relating to:

☐ Diagnoses and/or treatment for alcohol and/or drug abuse
☐ AIDS/AIDS related complex (ARC) diagnoses and/or Treatment
☐ HIV test results
☐ Diagnosis and/or treatment of other communicable diseases

Indicate here specific instructions, if any, regarding dates of treatment or amount of information to be released or obtained:

_____

The purpose of disclosure is:

☐ Continuity of Care
☐ Assisting in Assessment
☐ Coordination of Services
☐ Other: _____

This authorization shall remain in effect for: ☐ 90 days ☐ 180 days ☐ Other _____

- I understand that information used or disclosed as a result of this authorization may be re-disclosed by the recipient of my information and no longer protected by privacy practices.

Phone Number to reach Client/Guardian/Personal Representative: _____

_____ _____
Printed Name of Client | Signature of Client

_____ _____
Printed Name of Guardian/Personal Representative (If Applicable) | Signature of Guardian/Personal Representative (If Applicable)

_____ _____
Today's Date | Witness Signature and Date

Revocation: This authorization is subject to written revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke consent _____ _____
Client Signature and Date | Witness Signature and Date