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
F: 740-593-0091
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:

Agency: OhioHealth Campus Care

Address: Hudson Health Center, 2nd Floor

Phone: 740-592-7100 Fax: 740-592-7191

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