

Ohio University
Counseling and Psychological Services
Hudson Health Center, 3rd Floor
Athens, OH 45701
Ph: 740-593-1616 / Fax: 740-593-0091

Authorization for Release of Confidential Information

Client Name: _____ Date of Birth: _____

OU PID #: _____ Reach me by Phone at: _____

I hereby authorize: Staff members of Counseling & Psychological Services (refer to contact info above)

I received services from: _____

To obtain from or release to:

Person: _____

Agency: _____

Address: _____

Phone: _____ and Fax: _____

The following information:

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

The purpose of disclosure is:

- Communication with Third Party Continuity of Care
 Coordination of Services Assisting in Assessment
 Other: _____

This authorization shall remain in effect for:

- Thirty (30) days Sixty (60) days Ninety (90) days Other _____

- I understand that information used or disclosed as a result of this authorization may be re-disclosed by the recipient of your information and no longer protected by HIPAA Privacy Rules.
- You have the right to revoke this authorization, in writing, at any time by sending such written notification to Director, Counseling and Psychological Services. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization.

Printed Name of Client

Witness Signature

Signature of Client and Today's Date