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

Authorization for Release of Confidential Information

Client Name: _____ Date of Birth: _____

OU PID #: _____

I hereby authorize:		To Obtain From or Release To: (circle one)
☐J. Butcher-Winfree, M.A., M.S.	☐Michelle Pride, Ph.D.	_____
☐Paul Castelino, Ph.D.	☐ Jason Weber, M.Ed. LPC	_____
☐Jeanne Heaton, Ph.D.	☐Alfred B. Weiner, Ph.D.	_____
☐Matthew Lee, M.A.	☐ Sheila Y. Williams, Ph.D.	
☐Morgan Lucas, B.A.	☐ Susan B. Young, Ph.D.	
☐Candice Pennella	☐ Janice R. Carrick, D.O.	
☐Deanna Potkanowicz, Ph.D.	☐Curtiss B.Wright, D.O.	
☐ _____		

The following information:

_____ Assessment and Diagnosis
_____ Copy of Intake Note
_____ Copy of Progress Notes
_____ Verification of Attendance
_____ Copy of Psychiatric Notes
_____ Medication Information
_____ Copy of All Records
_____ Summary of Treatment
_____ School Records
_____ Other _____

The purpose of disclosure is:

_____ At My Request
_____ Coordination of Services
_____ Continuation of Care
_____ Developing Treatment Plan
_____ 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 redisclosed 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 Date