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 ☐ Medication Information
☐ Assessment and Diagnosis ☐ Summary of Treatment
☐ Psychiatric Treatment ☐ Other: ____

This Authorization includes release of records relating to:

☐ Diagnoses and/or treatment for alcohol and/or drug abuse ☐ HIV test results
☐ AIDS/AIDS related complex (ARC) diagnoses and/or Treatment ☐ 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 ☐ Coordination of Services
☐ Assisting in Assessment ☐ 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 HIPAA Privacy Rules.

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

____ ____
Printed Name of Client Signature of Client

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

Rev.07/18