AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This information may be released only with your written authorization and may be disclosed only for the purposes described below unless there is a serious or imminent threat to the health and safety of you or others. This form provides that authorization and helps make sure that you are properly informed of how this information will be used or disclosed.

Please read the information below carefully before signing this form.

I, or my authorized representative, request that health information regarding my care and treatment at _____ be release to the party(ies) named below.
(college or university)

ALL SEVEN SECTIONS MUST BE FULLY COMPLETED

1. Name of person whose information will be released:_____

   Date of Birth: ___ / ___ / ___

   Address: _____

   _____

2. Requested information to release (initial all that you authorize of):

   ____ Attendance (appointments scheduled and met; date of service)

   ____ Treatment (diagnosis and recommended treatment)

   ____ Safety concerns (level of danger to self and others)

   ____ Alcohol and other drug use

   ____ Written mental health records

   ____ Treatment summary

   ____ Academic-related issues

   ____ Billing records

   ____ Other: _____

   _____

   _____

3. Name(s) and address(es) of person(s) who will be receiving this information:

   _____
   _____
   _____
   _____

4. Expiration date: This authorization automatically expires 365 days from today's date, unless an earlier date or event is specified: _____

   _____

5. I understand:
   - What this release says and means. I had a chance to have my questions answered, and I voluntarily agree to this release.
   - Information shared based on this release may be further shared by the person receiving the information and will no longer be protected by state or federal confidentiality laws.
   - I have a right to a copy of this release.
   - I may view or get a copy of any health information or education records subject to this release.
   - I may refuse to sign this release. My refusal will not affect my ability to obtain present or future treatment, payment, enrolment or eligibility for benefits or educational services from the disclosing entity.
   - The authorization provided through this form means that the organization, entity or person authorized can disclose my protected health information to the organization, entity or person identified on this form, including through the use of any electronic means.

Signature: _____ Date: _____

Witness:_____ Date: _____

Please note that most colleges and universities will accept this release, however, may not communicate with authorized parties unless that college or university's-specific FERPA form is signed with the same authorized party(ies). This form is not an alternative to FERPA, but rather a supplemental release to demonstrate the student's written authorization.