

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Student Name: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- Treatment Summary
- Test Protocol/Test Report
- Counseling Record
- Problem Checklist
- Medication List
- Other _____

 Permission to release information to parents/guardian regarding my mental health status. (I realize that in any situation determined by a counselor to be a psychological emergency, my parents may be notified without my consent.)

4. I understand that the information in my record may include information relating to behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Address: _____
for the purpose of: _____

6. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Union College Counseling Center. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ . If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

7. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. If I have questions about disclosure of my health information, I can contact Marcus Hotaling, PhD, Director of Union College Counseling Center, Silliman Hall 3rd Floor, Union College, Schenectady, New York 12308, 518-388-6161.

You may accept a photocopy of this authorization and treat it as though it were an original signed by me.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient

Signature of Witness

The Union College Counseling Center and its employees are hereby released from all legal responsibility or liability for the release of the records to the extent indicated and authorized herein. I understand that by sending information by facsimile it is subject to viewing by unauthorized parties.