

## Consent and Authorization for Release of Health Information

Name of Student \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ or UPS ID# \_\_\_\_\_  
(Please print)

**I authorize University of Puget Sound Counseling, Health and Wellness (CHWS) to:**

Release information to the following:

Obtain information from the following:

Organization: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Telephone/Fax: \_\_\_\_\_

**The purpose for the release of information is (check all that apply):**

For treatment or referral

To verify treatment provided

To inform appropriate personnel with regard to the well-being of the client and/or community

Assessment of functioning request for study abroad program, Peace Corps, or other applications

Other (specify): \_\_\_\_\_

**Health information that may be released under this consent and authorization includes:**

All clinical medical records

Clinical records from: \_\_\_\_\_ to: \_\_\_\_\_

Clinical records concerning: \_\_\_\_\_

X-ray report (specify): \_\_\_\_\_

Immunization records

Other records (specify): \_\_\_\_\_

**Special consent and authorization:**

**I specifically request, consent to, and authorize the use and disclosure of the following protected personal medical information** (please read the information at the end of this document):

Drug use diagnosis and/or treatment

Alcohol use diagnosis/treatment

Sexually transmitted infection diagnosis/treatment

AIDS/HIV

Mental health and counseling records including:

Mental health assessment and diagnosis

Mental health treatment

Recommendations for further mental health treatment

Mandated substance abuse assessment

Other \_\_\_\_\_

Check if I give permission for information described under the special consent and authorization section to be redisclosed.

Patient's Initials

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I am not required to sign this consent and authorization. Signing this consent and authorization is not a condition of treatment, payment for any health care services or enrollment in a health plan, or eligibility for health care benefits.

If any of my health information is disclosed under this consent and authorization to a person or organization that is not covered by federal health information confidentiality laws, such as the Family and Educational Rights and Privacy Act or the Health Insurance Portability and Accountability Act, then such information potentially is subject to redisclosure.

I understand that I have the right to revoke this consent and authorization at any time by providing a written revocation to CHWS. Any revocation will not affect any uses, disclosures, or activities taken in reliance on this consent and authorization prior to my revocation. Unless this consent and authorization has been previously revoked, this consent and authorization shall expire in 90 days or:

Other (specify) \_\_\_\_\_

***I have read this consent and authorization and had an opportunity to have my questions answered. I understand this consent and authorization and am voluntarily signing it.***

Print Name: \_\_\_\_\_ Date : \_\_\_\_\_

Signature: \_\_\_\_\_ Tel #: \_\_\_\_\_

Describe authority if not signed by the student: \_\_\_\_\_

### **Additional Information**

#### Processing Requests:

It may take up to 15 business days to complete any request for health information to be duplicated and mailed to a third party. If you have not anticipated this lead time, let us know; we may be able to expedite. There may be a charge for duplicating records. The costs are as follows: 1-4 pages: no charge; 5-15 pages: \$5; 16-40 pages: \$10; over 40 pages: \$20.

#### Drug and Alcohol Abuse Treatment Information:

Federal regulations prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or as otherwise permitted by federal law. Accordingly, CHWS will include the following statement with any disclosure of this type of information:

“This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”

#### Sexually Transmitted Disease/AIDS/HIV Information:

State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or as otherwise permitted by state law. Unless redisclosure is specifically permitted, any such information disclosed pursuant to this consent and authorization will be accompanied by the following notice: This information has been disclosed to you from records whose confidentiality is protected by state law.

“State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. A general authorization to release information is not sufficient for this purpose.”

Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violation.