Center for Counseling and Psychological Services
The Pennsylvania State University
501 Student Health Center
University Park, PA 16802-4601

(814) 863-0395
FAX: (814) 863-9610

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, ____ (DOB:_____ ______) voluntarily authorize
(Client's name) (mm/dd/yr)

the Center for Counseling and Psychological Services (CAPS) to:

________ Exchange information of information necessary to coordinate mental health and/or medical care

_________ Release records/information concerning my mental and/or medical health evaluation/treatment to:

_________ Obtain records/information concerning my mental and/or medical health evaluation/treatment from:

____
(Name of agency or person)

____
(Address of agency or person, including city, state, and zip code)

____

____
(Optional: Phone and fax numbers)

This authorization is valid for up to 1 year from date of signature or expires on the following earlier date: ____________________

(If Applicable) Dates of treatment: ____________________ to ______________________________

The information released will be disclosed for the following reason(s):

_______ Confirm attendance _______ Continued care _____ Coordination of health care benefits
_______ Provide information _______ Other (specify): ____

The specific and relevant type of information I wish to have released is:

_______ Treatment summary
_______ Dates of counseling appointments/treatment
_______ Treatment recommendations
_______ Testing/Assessment results
_______ Other (specify) __________________________
_______ Psychiatric eval and diagnoses
_______ Psychiatric progress notes
_______ Counseling progress notes and diagnoses
_______ Insurance coverage and benefits
_______ All treatment records

I understand that my record(s) may contain information related to alcohol/drug use, sexually transmitted diseases, sexual assault, and/or mental health. This information will be disclosed unless I specify that the information **NOT** be disclosed by **initialing**:
_____ Alcohol/drug use _____ Sexually transmitted diseases (e.g., HIV) _____ Sexual assault ______ Mental health

I understand authorizing the use or disclosure of the information identified above is voluntary. I understand that my treatment at CAPS is not conditional on my signing an authorization. I understand I have the right to revoke this authorization at any time by written request. However, my revocation will only apply to future disclosures and is not retroactive. Please refer to the Notice of Privacy Practices for exceptions for revocation. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

____ ____________________________
Client signature Date

____
Penn State ID number

Would you like a copy of this authorization?
______ Yes ______ No
(Please check)

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Doctoral Internship in Professional Psychology Accredited by the American Psychological Association