PennState Student Affairs

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/yyyy)

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

- ○ Exchange 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 will expire (choose one):

- ◉ upon my graduation *or*
- ○ year from today's signature *or*
- ○ Date: _____ (mm/dd/yyyy)

(Optional) This authorization is limited to the following dates of treatment:

_____

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

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

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's Full Name (first, middle, last) Today's Date (mm/dd/yyyy)

_____ _____
Penn State ID Number Date of Birth (mm/dd/yyyy)

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