PURDUE UNIVERSITY
PURDUE STUDENT HEALTH CENTER (PUSH)
COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)
AUTHORIZATION FOR USE, DISCLOSURE AND/OR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize the use, disclosure and/or release of confidential or protected health information, including my social security number, which is contained in the health record of:

Patient's Name: _____ Date of Birth: _____

Patient's Address (Street): _____

(City, State, Zip Code): _____

Patient's I.D.#: _____ Phone #: _____

Please describe specifically what health information may be used or released:

Mental health and/or medical health information as it pertains to my treatment and/or care coordination for my eating disorder. Only the minimum necessary information will be shared for this purpose.

If this request is not made by the patient, what is the reason for this request?

Communication of patient's treatment and care coordination.

Please identify who is to disclose and receive the medical records or other medical information:

I authorize members of **Purdue's Student Health Center, Counseling and Psychological Services (CAPS), Eating Disorders Treatment Team*, and Dean of Student's Office** to disclose and receive the confidential health information described above.

The Purdue University Eating Disorders Treatment Team consists of the ***current representative(s)*** from the following University entities.
Athletics Department
Counseling and Psychological Services (CAPS)
Office of the Dean of Students (ODOS)
Other visiting Purdue faculty or staff, if appropriate
Purdue University Student Health Center (PUSH) medical providers
Recreational Sports Center (RSC)
Student Wellness Office dietitian

Patient's Initials _____

Unless the "No" box is marked, this authorization extends to such psychiatric, mental health, and drug and alcohol abuse treatment information, if any, as may be contained in said medical record including information protected by I.C. 16-39-1-9, I.C. 16-39-2-1 through 16-39-4-2 and I.C. 16-41-8-1. This release permits re-disclosure in accordance with 42 C.F.R., Part 2, which is a federal regulation governing release and use of medical information pertaining to treatment for alcohol or drug abuse. ☐ No

Unless the "No" box is marked, the authorization also extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), if contained in said medical record. ☐ No

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy regulations.

I understand that CAPS will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of medical records or other medical information. I may inspect or request a copy of any information used or disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by mailing or delivering a written revocation to CAPS, 703 Third St. Rm 1120, West Lafayette, IN 47907. The revocation will be effective upon receipt by CAPS, except to the extent that CAPS has taken action in reliance on this authorization. I further understand that this authorization will expire as follows: (1) sixty (60) days from the Signature Date for all records except mental health records, and (2) one hundred eighty (180) days from the Signature Date for mental health records, unless I specify a different expiration date or event here: _____. After the expiration date, this authorization will no longer be effective, and no further information will be furnished pursuant to it.

I understand that there may be a charge to cover actual costs incurred by Purdue University in preparing and delivering the information requested in this authorization, in accordance with Indiana statutes and Purdue policies.

Signed: _____ _____

Patient or Legal Representative *Date*

_____ _____

Printed name if not patient *Relationship if not patient*

Witness: _____ _____

Date

☐ Patient was offered a copy of this form and declined