PURDUE UNIVERSITY

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 in verbal or written form which is contained in the mental health record of:

Patient's Name: _____ **Date of Birth**: _____
Street Address: _____ **City, State, Zip Code:** _____
PUID: _____ **Telephone:** _____

- Please identify or describe specifically what mental health information may be used, released or discussed: ☐ Intake Report; ☐ Diagnosis; ☐ Termination Summary; ☐ Dates of Treatment; ☐ Assessment Summary; ☐ Psychiatric Evaluation; ☐ Summary Letter; ☐ Other (you must specify, including if you'd like us to release your entire mental health record): _____
  _____

- Reason for this request: ☐ Request made by patient; ☐ Coordination of services; ☐ Personal use, ☐ Legal purposes; ☐ Continuity of care; ☐ Other:_____

- Please **initial** either or both space(s) below, as applicable:

_____I authorize Counseling and Psychological Services (CAPS) and its employees to **disclose** the confidential information described above to the following person, healthcare provider, or company:

_____I authorize the following person, healthcare provider or company to disclose the confidential information described above to CAPS, thus allowing CAPS to **obtain** the information from:

Name of person(s) or entity: _____
Street Address: _____ **City, State, Zip Code:** _____
Telephone: _____ **Fax:** _____

Unless the "No" box is marked, this authorization extends to drug and alcohol abuse treatment information, if any, as may be contained in said medical record to be released. 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, this authorization extends to information regarding communicable diseases, including human immunodeficiency virus (HIV), and AIDS related complex (ARC) and acquired immunodeficiency syndrome (AIDS), to be released if contained in said medical record. **No**

I understand that the information released will include mental health and psychiatric records if included in the records designated. 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, 601 Stadium Mall Drive, 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 on May 10, 2020**, 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: _____ **Date:** _____
Patient or Legal Representative
Printed Name, if not patient: _____ *Relationship:*_____

☐ Patient was offered a copy of this form and declined
☐ Patient received a copy of this form

PSYC ■ 703 Third Street ■ West Lafayette, IN 47907-2081 ■ (765) 494-6995 ■ Fax: (765) 496-3004
PUSH ■ 601 Stadium Mall Drive ■ West Lafayette, IN 47907-2052 ■ (765) 494-6995 ■ Fax: (765) 496-2139