

Counseling Services Student Counseling Center

Kanbar 323 833 Chestnut St., Suite 230

Phone: 215-951-2868 Phone: 215-503-2817

**Release of Information Authorization Form**

**Client Name:** add your name here **Student ID**: add your student ID **D.O.B:** add your DOB

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, and/or treatment for drug and alcohol abuse. Please check the appropriate box(es):

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| --- | --- | --- |
| **AIDS/HIV** | **PSYCHIATRIC CARE/TREATMENT** | **DRUG OR ALCOHOL TREATMENT** |
| Yes, disclose | Yes, disclose **X** | Yes, disclose **X** |
| No, do not disclose **X N/A** | No, do not disclose | No, do not disclose |

\*\*I have been informed of my right to inspect my mental health records, subject to the limitations imposed by 55 Pa. Stat.5100.33

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| 1. I, add your name, hereby authorize Jefferson Counseling Services to release the following information: |

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| X Attendance X Treatment Summary X Treatment Records Other:  For the purpose of: X Continuity of Care Attorney/Legal X Consultation Other:  This information is to be released to (Name/Agency/Contact Info): add your other provider’s name/email/phone here |

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| --- |
| 1. I, add your name, hereby authorize add your other provider’s name/email/phone here |

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| To release Jefferson Counseling Services the following information:    X Attendance X Treatment Summary X Treatment Records Other:  For the purpose of: X Continuity of Care Attorney/Legal X Consultation Other: |

1. This authorization will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or one year from effective date.
2. I understand that this authorization may be revoked at any time by written communication to Counseling Services except to the extent that information has already been disclosed. If information has already been disclose in reliance on this authorization, revoking it will only prevent future disclosure.
3. I understand that information (except drug and alcohol information) disclosed pursuant to this authorization may be subject to redisclosure and is no longer protected by federal privacy regulations.
4. I understand that Counseling Services, Jefferson its Board of Trustees, officers are hereby released from any legal responsibility of disclosure of the above information to the extent indicated and authorized.
5. I understand that I may refuse to sign this authorization.

SIGNATURE: \_\_\_\_\_\_\_add your name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: add today’s date