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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION



I, _____, authorize Lewis & Clark Counseling Service staff to:
(print name)

___ obtain the following information from

___ release the following information to

Name of person /agency: _____

Address and phone, if available: _____

(Describe below information to be used/disclosed)

- ___ Confirmation of my attendance at counseling sessions
- ___ Current treatment plan or related information
- ___ Outpatient mental health assessment and treatment records
- ___ Hospital records related to mental health assessment/treatment
- ___ Other: Please describe: _____

This information will be used for the following purposes:

- ___ Assessment
- ___ Treatment planning
- ___ Other: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this type of information will be disclosed if I place my initials in the applicable space next to the type of information.

- | | |
|-------------------------------|--|
| ___ HIV / AIDS information | ___ Genetic testing information |
| ___ Mental health information | ___ Drug/alcohol diagnosis, treatment, or referral information |

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV / AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment or referral information.

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to Dr. John Hancock, Associate Dean of Students/Director of Wellness Services/Chief Psychologist (MSC 135—Counseling) at Lewis & Clark College and state that you are revoking this authorization.

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires at the end of the current academic year (May 31).

By: _____ Date: _____
(Signature)