Lewis & Clark College

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Counseling Service
MSC 135

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I , _____, date of birth _____, 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
_____ Mental health information
_____ Genetic testing 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 end of current academic year (May 31).

By: _____ Date: _____
(Signature of individual)