AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Center for Health and Well-Being, Coastal Carolina University – Counseling and Psychological Services (CAPS) **COMPLETE IN FULL**

Name - (i.e., health facility, physician, etc.):	1.	PATIENT INFOR	RMATION	ī :								
CCUI Do or SS#: Bieth date:	Na	nme – Last, First, MI										
2. RECORDS RELEASED FROM: Same = 1.6. Leasth facility, physician, etc.)* Conseiling and Psychological Services - Constal Carolina University	Local Student Address or CCU Box:					Telephon	Telephone number:					
2. RECORDS RELEASED FROM: Name—i.e., bothly facility, physician, etc.): Constelling and Psychological Services—Constal Carolina University Society Address: 250 University Bird. City: Society Soci	City: State:								Zip Code:			
Name - (i.e., health facility, physician, etc.):	CCU ID or SS#:						Birth date:					
Name - (i.e., health facility, physician, etc.):							<u> </u>					
Counseling and Psychological Services - Constal Carolina University Financial Aid Office	2.											
Studies Studies Studies Studies Species Spec	Counseling and Psychological Services - Coastal Carolina University						Coastal Carolina University - Financial Aid Office					
Convay SC 29526 Phone: Fax: Phone: Phone: Fax: Phone: Phone						Stree	et Ac	ldress:				
NOTICE: Confidential health information is protected by state and federal law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) 1996 and related regulations regarding to re-disclosure and are not protected by this authorization and certain federal regulations dealing with the privacy of individually identifiable health information (45 CFR Part 164, Subpart E.) 4. REASON FOR DISCLOSURE: Further Medical Care		•				City:			State:	State: Zip code:		
of 1996 and related regulations. Please note that once the requested records are provided to another party by the Center for Health and Well-Being, those records may be subject to re-disclosure and are not protected by this authorization and certain federal regulations deading with the privacy of individually identifiable health information (45 CFR Part 164, Subpart E.) 4. REASON FOR DISCLOSURE: Gruther Medical Care					6	Pho	ne:			Fax:		
Further Medical Care	o	f 1996 and related regulati	ions. Please no	ote that once the	requested records are provion and certain federal regula	ided to another ations dealing v	party	y by the Center	for Health and	Well-Being, th	hose records may be subject	
Changing or New Physician/Therapiss Outpatient Care Psychological Assessment Counseling Treatment/Consult Personal Counseling Treatment Records/Information Assessment Prescriptions Academics Accessibility & Disability Academics Counseling Treatment Records/Information Academics Prescriptions Accessibility & Disability Academics Prescriptions Academics Permission to Speak (as identified in section 3) Other Psychological Withdrawal Counseling and Consultation Visit Counseling and Consult	4.	REASON FOR D		5	. Protecte	d Health In	formation	TO BE RELEASED:				
Mental Health Treatment/Consult						Date(s)						
Medication Evaluation					=			-				
Academics Academics Higher Level of Care Counselor Notes Permission to Speak (as identified in section 3) Other: Psychological Withdrawal Counseling and Consultation Visit Counseling and Consultation Visit Counseling and Consultation Visit Counseling and Consultation Visit Counseling and Consultation Visit Counseling and Consultation Visit Letter of Summary Letter of Summary		☐ Medication Evaluation☐ Assessment☐ Accessibility & Dis										
Permission to Speak (as identified in section 3) Other: Psychological Withdrawal Counseling and Consultation Visit						sability						
Counseling and Consultation Visit						are						
A detailed message may be left on my cell phone:		☐ Permission to Speak	\square Permission to Speak (as identified in section 3) \boxtimes Other: Psychologic									
Number:		_					•					
□ I give CAPS permission to speak with my academic administrator,	6.	☐ A detailed messag		☐ Letter of Summary								
7. PATIENT RIGHTS: I have had the opportunity to read this facility's Notice of Privacy Practices and have had all of my questions regarding this Notice answered to my satisfaction. I understand that only health care providers, plans, and clearing houses must follow the federal privacy standards. If an individual or organization receiving my protected health information (PHI) does not fall into one of these categories, this authorization ceases to be protected by the federal privacy standards, allowing for the possibility of my PHI being redisclosed without further authorization. I understand that I may cancel this authorization but that my withdrawal is only effective to the extent that action has not already been taken, as a result of my signing this form. In order to withdraw this authorization, written notification is required. Unless otherwise revoked, this authorization will expire on (date or event)												
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from the date of my signature. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. Patient signature/legal representative Date If the signor is not the patient, state the relationship and authority to do so Witness Type of identification presented FOR OFFICE USE ONLY Date (PHI) released (fax, mail, email): Signature: Comments:	I ha onl doe fur sig	ave had the opportunity to y health care providers, pl es not fall into one of these ther authorization. I under- ning this form. In order to	read this facil ans, and clear e categories, the stand that I ma withdraw this	ing houses mus his authorization ay cancel this au authorization,	follow the federal privacy ceases to be protected by the atthorization but that my with written notification is require	standards. If ar he federal priva hdrawal is only red.	n indi acy si v effe	ividual or organ tandards, allowi ective to the exte	ization receiving for the possent that action h	ng my protecte sibility of my F nas not already	d health information (PHI) PHI being redisclosed without been taken, as a result of my	
Patient signature/legal representative Date If the signor is not the patient, state the relationship and authority to do so Witness Type of identification presented FOR OFFICE USE ONLY Date (PHI) released (fax, mail, email): Signature: Comments:				n will expire or	(date or event)	If I fail to	o spe	ecify an expiration	on date or even	it, this authoriz	cation is valid for one (1) year	
If the signor is not the patient, state the relationship and authority to do so Witness Type of identification presented FOR OFFICE USE ONLY Date (PHI) released (fax, mail, email): Signature:	I ha	ave had an opportunity to i	review and un	derstand the co	ntent of this authorization fo	orm. By signing	g this	authorization, l	I am confirmin	g that it accura	ately reflects my wishes.	
Type of identification presented FOR OFFICE USE ONLY Date (PHI) released (fax, mail, email): Signature: Comments:	Patient signature/legal representative						Date					
FOR OFFICE USE ONLY Date (PHI) released (fax, mail, email): Signature: Comments:	If the signor is not the patient, state the relationship and authority to do so						Witness					
FOR OFFICE USE ONLY Date (PHI) released (fax, mail, email): Comments:	Ty	pe of identification pres	sented			. 						
Comments:												
Comments:	Da	te (PHI) released (fax,	mail, email):				Sigr	nature:				
	Co	mments:										
Use this space only to withdraw consent												

I withdraw my consent to release any information that has not already been released as a result of prior authorization. Signature of Client (or Legal Guardian)