AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Counseling Services, Coastal Carolina University
COMPLETE IN FULL.

1. Patient Information:

Name - Last, First, MI		
Local student address or CCU box		Telephone number
City	State	ZIP code
CCU ID or SS#	Birth date	

2. Records Released From:

Name - (i.e., health facility, physician...)		
Street address		
City	State	ZIP code
Phone	Fax	

3. Records Released To:

Name - (i.e., insurance, lawyer, physician, academics, and self...) Provost Office Personnel		
Street address		
City	State	ZIP code

NOTICE: Confidential health information is protected by state and federal law, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and related regulations. Please note that once the requested records are provided to another party by Counseling Services, those records may be subject to re-disclosure and are not protected by this authorization and certain federal regulations dealing with the privacy of individually identifiable heath information (45 CFR Part 164, Subpart E).

4. REASON FOR DISCLOSURE:

- ☐ Further Medical Care
- ☐ Changing or New Physician/Therapist
- ☐ Mental Health Treatment/Consult
- ☐ Medication Evaluation
- ☐ Academics
- ☐ Inpatient Care
- ☐ Permission to Speak (as identified in section 3)
- ☐ Legal Inquiry
- ☐ Outpatient Care
- ☐ Personal
- ☐ Assessment
- ☐ Accessibility & Disability
- ☐ Higher Level of Care
- x☐ Other: Request for Psychological Withdrawal

5. Protected Health Information TO BE RELEASED:

Date(s) of treatment/visit:_____

- x☐ Psychological Assessment
- x☐ Counseling treatment records/information
- ☐ Prescriptions
- x☐ Attendance
- ☐ Counselor Notes
- ☐ Mental Health Treatment/Consult
- ☐ Counseling and Consultation Visit
- ☐ Letter of Summary

6. ☐ A detailed message may be left on my cellphone.

Number:_____

☐ I give Counseling Services permission to speak with my academic administrator_____about matters pertaining to my psychological withdrawal.

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)_____. If I fail to specify an expiration date or event, this authorization is valid for one (1) year 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 relationship and authority to do so Witness

_____
Type of identification presented

----------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) _____

FOR OFFICE USE ONLY

Date PHI released (fax or email) _____ _____
Signature

Comments _____