UNIVERSITY of PUGET SOUND
Counseling, Health, & Wellness Services

General Authorization

1500 North Warner St, CMB # 1035, Tacoma WA 98416-1035 * PH: 253-879-1555 * Fax: 253-879-3766 * TDD: 253-879-3964

Consent and Authorization for Release of Health Information

Name on requested medical record: _____ DOB: _____

Chosen name: _____ UPS ID #: _____

I authorize University of Puget Sound Counseling, Health, & Wellness (CHWS) to:

☐ Release information to the following: ☐ Obtain information from the following:

Organization:_____

Name:_____

Address:_____

City/State:_____

Zip code: _____

Telephone: _____ Fax: _____

The purpose for the release of information is (check all that apply):

- ☐ For treatment or referral
- ☐ To verify treatment provided
- ☐ To provide a statement of readiness for participation in a program or activity
- ☐ To confirm medical or mental health conditions for purposes of accommodation
- ☐ Other (specify):_____

Health information that may be released under this consent and authorization includes:

- ☐ All clinical medical records
- ☐ Clinical records from: _____ to: _____
- ☐ Clinical records concerning: _____
- ☐ Immunization records
- ☐ Billing records
- ☐ Other records (specify): _____

Special consent and authorization:
I specifically request, consent to, and authorize the use and disclosure of the following personal health information (please check individual boxes and then read the additional information at the end of this document):

- ☐ Drug use diagnosis and/or treatment
- ☐ Alcohol use diagnosis/treatment
- ☐ Sexually transmitted infection diagnosis/treatment
- ☐ AIDS/HIV
- ☐ Mental health and counseling records including:
  - ☐ Mental health assessment and diagnosis
  - ☐ Mental health treatment
  - ☐ Recommendations for further mental health treatment
- ☐ Mandated substance abuse assessment
- ☐ Other _____

Initials

Please complete back side of form

I am not required to sign this consent and authorization. Signing this consent and authorization is not a condition of treatment, payment for any health care services, enrollment in a health plan, or eligibility for health care benefits.

If any of my health information is disclosed under this consent and authorization to a person or organization that is not covered by federal health information confidentiality laws, such as the Family and Educational Rights and Privacy Act or the Health Insurance Portability and Accountability Act, then such information potentially is subject to redisclosure.

I have read this consent and authorization and had an opportunity to have my questions answered. I understand this consent and authorization and am voluntarily signing it.

I understand that I have the right to revoke this consent and authorization at any time by providing a written revocation to CHWS. Any revocation will not affect any uses, disclosures, or activities taken in reliance on this consent and authorization prior to my revocation. Unless this consent and authorization has been previously revoked, this consent and authorization shall expire one year from date signed or:

☐ ***Other (specify date):*** _____

Print Name:_____ Date : _____

Signature:_____ Tel #: _____

Describe authority if not signed by the student:_____

Additional Information

Processing Requests:
It may take up to 15 business days to complete any request for personal health information to be duplicated and mailed to a third party. If you have not anticipated this lead time, let us know; we may be able to expedite. There may be a charge for duplicating records. The costs are as follows: 1-4 pages: no charge; 5-15 pages: $5; 16-40 pages: $10; over 40 pages: $20.

Drug and Alcohol Abuse Treatment Information:
Federal regulations prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or as otherwise permitted by federal law. Accordingly, CHWS will include the following statement with any disclosure of this type of information:

> "This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Sexually Transmitted Disease/AIDS/HIV Information:
State law prohibits any further disclosure of this information without specific written consent of the person to whom the information pertains, or as otherwise permitted by state law. Unless redisclosure is specifically permitted, any such information disclosed pursuant to this consent and authorization will be accompanied by the following notice: This information has been disclosed to you from records whose confidentiality is protected by state law.

> "State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. A general authorization to release information is not sufficient for this purpose."

Any violation of the law is a gross misdemeanor, and the law creates civil remedies for any violation.