Authorization to Obtain or Release Information

Converse College Wellness Center
Counseling Services

580 E. Main St. Spartanburg, SC 29302 ◆ Phone: (864) 596-9258 ◆ Fax: (864) 596-9729

Instructions: Please complete all sections of this form. Please note that incomplete or inaccurately completed forms will not be honored.

Student name: _____

Social security number: _____ Date of birth: _____

I hereby authorize the Converse College Wellness Center to (check one):

❑ release information to: ❑ obtain information from: ❑ exchange information with:

Individual, provider, or organization: _____

Address: _____

Phone number: _____ Fax number: _____

Purpose of request (check one or more):

❑ Assessment/diagnosis
❑ Treatment planning
❑ Coordination of services

❑ Other: _____

Types of records authorized (check one or more):

❑ All records ❑ Assessment(s)
❑ Attendance ❑ Progress notes

❑ Other: _____

*** Please note: "Psychotherapy notes" cannot be disclosed pursuant to this Authorization.

This authorization will expire:

❑ When the requested information has been sent/received
❑ When I am no longer receiving services from the College Counseling Center
❑ In one year
❑ Other: _____

I understand that:

- I do not have to sign this authorization and my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to the College Counseling Center, except where a disclosure has already been made based on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- If the medical record information is not sent to another care provider, there may be a charge for the requested records.

By signing below, I acknowledge that I have read and understand the above statements. I have had the opportunity to ask questions about the statements above and to request a copy of this form.

_____ _____

Client Signature *Date*

_____ _____

Staff Signature *Date*

_____ _____

Parent/Guardian Signature (if client under 18) *Date*

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). 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. (§ 2.32 Prohibition on Redisclosure)