University Counseling and Testing Center (UCTC)

300 Alumni Circle, Mobile, AL 36688/(Telephone) 251-460-7051/(Fax) 251-460-7492

Authorization for Release of Protected Health Information (PHI)

NAME:_____ DATE OF BIRTH_____/_____/_____

ADDRESS_____

PHONE NO. (_____)_____ J NUMBER _____

I hereby authorize the UCTC or any of its staff to use, disclose, or obtain by any acceptable means, including fax, phone, or email my Protected Health Information.

Check the one that applies: Use PHI ☐ Disclose PHI ☐ Obtain PHI ☐

Dates of records to be released: _____

PHI to be used, disclosed, or obtained:

☐ All records
☐ Intake information
☐ Treatment plan
☐ Treatment summary
☐ Attendance information
☐ OTHER _____

To the following persons or class of persons:

☐ Student Health Center
☐ Student Disability Services
☐ Dean of Students Office
☐ Treatment Provider (*fill in information below*)
☐ Parents/Other Family (*fill in information below*)
☐ OTHER _____

RECIPIENT'S NAME: _____ ADDRESS: _____

_____PHONE: _____ FAX: _____

The purpose of this use, disclosure or obtainment is:

☐ At the request of the client
☐ Coordination/Continuity of Care
☐ Letter of Support
☐ OTHER _____

By providing this authorization, I understand the following:

1. That such PHI may contain information concerning psychiatric, psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment, and care of sexually transmitted disease or complications related to sexually transmitted diseases, including but not limited to HIV testing and test results.
2. That the PHI to be disclosed may be subject to re disclosure by the recipient of the PHI and no longer protected by federal Privacy rules.
3. That I may revoke this authorization at any time notifying UCTC in writing but if I do it will not have any effect on uses or disclosures of PHI prior to receipt of revocation.
4. This Authorization for Disclosure of Protected Health information shall be effective for a period of one year from the date signed unless earlier revoked or alternate date is specified here _____/_____/_____.
5. That the employees, psychologists, and/or counselors are released from any legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.
6. That I may receive a copy of this authorization form after I sign it.

_____ _____

Signature of Client or Client's Legal Guardian **Date**

_____ _____

Printed Name of Client's Representative (if applicable) **Representative's Relationship to Client**