**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** REQUEST AND/OR AUTHORIZE Northern Kentucky University’s Health, Counseling and Student Wellness (HCSW) to release to and/or receive from:

Name: **person or company you want to release information to and from.**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.** Fax: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The following information from my treatment record:

complete Health Services record complete Counseling Services record

dates of Health Services treatment dates of Counseling Services treatment attendance

Other (specify**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The Medical Record Information will be used and/or disclosed for the following purpose:

Request of Individual Changing primary care provider Specialty care  Other (specify**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that in signing this form and authorizing release of the requested information that:

* HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

Do not release HIV-related information

Do not release drug and alcohol information

* Confidential information provided to HCSW by other individuals or agencies will not be included in the released record.
* If my confidential information is disclosed to someone who is not required to comply with federal privacy protection rules, then such information may be re-disclosed and would no longer be protected.
* This consent will automatically expire one (1) year after the date of signature unless another date is specified.
* I have the right to refuse to sign this form, in which case I understand my record will not be sent, and that I may revoke my consent in writing at any time, except to the extent that the information has already been released.
* Refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature Date of Birth Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/Guardian Signature (if applicable) Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Witness Signature Date

To be completed by Health, Counseling & Student Wellness staff

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **PHOTO IDENTIFICATION IS REQUIRED TO PICK UP MEDICAL RECORDS**

HCPS Staff Signature Date Records Released