AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Center for Health and Well-Being, Coastal Carolina University – Counseling and Psychological Services (CAPS)
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, etc.): **Counseling and Psychological Services – Coastal Carolina University**		
Street Address: 251 University Blvd.		
City: Conway	State: SC	Zip code: 29526
Phone: 843-349-6543	Fax: 843-349-6546	

3. RECORDS RELEASED TO:

Name – (i.e., health facility, physician, etc.): **Coastal Carolina University - Financial Aid Office**		
Street Address:		
City:	State:	Zip code:
Phone:	Fax:	

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 the Center for Health and Well-Being, 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 health 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
☒ Other: **Psychological Withdrawal**

5. Protected Health Information TO BE RELEASED:

Date(s) of treatment/visit:_____
☒ Psychological Assessment
☒ Counseling Treatment Records/Information
☐ Prescriptions
☒ Attendance
☐ Counselor Notes
☐ Mental Health Treatment/Consult
☐ Counseling and Consultation Visit
☐ Letter of Summary

6. ☐ A detailed message may be left on my cell phone:

Number:_____

☐ I give CAPS 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 the relationship and authority to do so Witness

_____
Type of identification presented

FOR OFFICE USE ONLY

Date (PHI) released (fax, mail, email):_____ Signature:_____

Comments:_____

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