Northern Arizona University
Counseling Services
Flagstaff, AZ 86011-6045
928-523-2261; Fax: 928-523-9060

AUTHORIZATION FOR USE, DISCLOSURE AND/OR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize the release, disclosure and/or exchange of confidential or protected health information in verbal, electronic, or written form, which is contained in the mental health record of:

Client's Name:_____**Date of Birth**:_____
Street Address:_____**City, State, ZipCode:**_____
NAUID:_____**Telephone:**_____

Please identify or describe specifically what mental health information may be obtained, released or exchanged: (check all that apply)
__ Summary of Treatment including diagnosis, dates of attendance, and treatment progress
__ Verification of Treatment/Attendance
__ Other:_____

Reason for this request: (check all that apply)
__ Coordination of services/Continuity of Care □ Academic withdrawal/coordination
__ Other:_____

I authorize NAU CS to [ ] Release my information to: [ ] Obtain my information from: [ ] Exchange my information with:

Name of person(s) or entity:_____
Street Address: _____ **City, State, Zip Code:**_____
Telephone: _____ **Fax**_____

I understand that upon release and disclosure of the protected medical records and information, the records and information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I check the box in the space to the left of the type of information.

__ I give my permission for the release of information regarding assessment, diagnosis, and treatment of alcohol and/or substance abuse.
__ I give my permission for the release of information regarding diagnosis and/or treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or HIV status.

I understand that Counseling Services will not deny treatment, payment, enrollment or eligibility for benefits based upon whether I sign this authorization. I also understand that an authorization may be necessary in order to process any request I have made for a release of mental health information. I may inspect or request a copy of any information used or disclosed under this authorization.

I understand that I may revoke this authorization at any time by submitting a *Revocation of Authorization* form to my counselor. The revocation will be effective upon receipt, except to the extent that information has been released in accordance with this authorization. I further understand that this authorization will **expire one year from today's date** unless I specify a different expiration date or event here:_____. After the expiration date, this authorization will no longer be effective, and no further information will be furnished pursuant to it.

*Signed:*_____ *Date:*_____
(Client or Parent if client is under 18 yrs of age)

*NAU ID:*_____ *DOB:*_____

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CLIENT'S RIGHTS
REGARDING SHARING OF INFORMATION

Before completing the authorization to have information released, exchanged, or obtained, please read the following:

1. Your eligibility for Counseling Services is not impacted by your decision to sign this form.

2. Your signature on this form authorizes either your counselor or NAU's Counseling Services to release, exchange or obtain information to/with/from **only** the person or agency named on the form.

3. You have the right to have your counselor explain what type of information will be released, exchanged, or obtained.

4. You have the right to revoke this authorization at any time by submitting a Revocation of ROI form. If you do not submit a Revocation form, this authorization expires as specified on the other side of this form.

Date Received: _____

Date Information Sent: _____

Therapist(s): _____

Signature: _____