



GEORGETOWN UNIVERSITY

Counseling and Psychiatric Service

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Name: _____

Date of Birth: _____

I hereby authorize the Counseling and Psychiatric Service at Georgetown University to exchange protected health information below with these parties:

Requested information:

I authorize the exchange of the following types of records, created from _____ to _____:
(date) (date)

- Attendance (appointments scheduled and met; dates of service)
- Safety concerns (level of danger to self or others)
- Alcohol and other drug use
- Written mental health records
- Treatment plan
- Treatment summary
- Academic related issues
- Other: _____
- Billing records

The purpose of the Requested Use or Disclosure is:

- At the request of the patient
- To address academic concerns
- Other: _____
- For continuity of care
- For medical leave of absence or assessment for return
- For coordination of care

I understand that:

1. My authorization of disclosure of this information can be revoked by providing a dated and signed written revocation to CAPS. However, mental health information disclosed before the receipt of my written revocation may be used for the purposes stated above.
2. This authorization applies only to the disclosure of mental health information which exists as of today.
3. Information disclosed to a healthcare provider or health plan, in accordance with my authorization, cannot be further disclosed by the recipient without my consent, unless otherwise authorized by law.
4. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
5. Within the provisions of the Mental Health Information Act, I have a right to review the mental health information contained in my record.
6. I may refuse to sign this authorization. My refusal will *not* affect my ability to obtain treatment or payment.

Expiration Date: This authorization expires in 60 days from today's date, or this earlier date: _____, or when the following event occurs: _____

Signature of Patient _____

Date _____

Signature of Witness _____

Date _____

Printed Name _____

Printed Name _____