

## AUTHORIZATION FOR RELEASE OF RECORDS OR INFORMATION

I, \_\_\_\_\_, hereby give permission to Texas Wesleyan University Community  
(Print name of client)

Counseling Center or its affiliates (collectively Texas Wesleyan University), and the student counselors and/or clinician(s) performing services on behalf of Texas Wesleyan University in connection with my counseling to:

**Disclose Information to:** \_\_\_\_\_ **AND/OR** \_\_\_\_\_  **Obtain Information from:** \_\_\_\_\_

\_\_\_\_\_  
(Name of agency, attorney, clinician, physician, school counselor, client, other)

\_\_\_\_\_  
(City, State, Zip Code)

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### DISCLOSED/OBTAINED INFORMATION (VERBALLY, WRITTEN/TYPED, OR PHOTOCOPIED):

**MY ENTIRE COUNSELING RECORD; OR**

**ONLY** the following information: (CLIENT MUST INITIAL EACH ITEM TO BE RELEASED/OBTAINED BELOW)

\_\_\_\_\_ Diagnostic Impression/Assessment \_\_\_\_\_ Counseling Recommendations/Plan \_\_\_\_\_ Substance Abuse Eval.

\_\_\_\_\_ Attendance Records Only \_\_\_\_\_ Progress Report on my Counseling \_\_\_\_\_ Name of Referral Provider

\_\_\_\_\_ Expected Length of Counseling \_\_\_\_\_ Other (specify): \_\_\_\_\_

The purpose for such disclosure:  to permit continuity of care  requested by the client for personal/private use

other (specify): \_\_\_\_\_

***I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release as well as my private mental health information shall be considered as effective and valid as the original.***

***I further understand the potential exists for re-disclosure of my personal mental health information, and that it may no longer be protected under the HIPAA privacy regulations.***

***I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with Texas Wesleyan University Community Counseling Center and its affiliates.***

***This is to certify that I have given consent freely and voluntarily, and the benefits and disadvantages of releasing the information, if known, have been explained to me.***

\_\_\_\_\_  
(Signature of client)

\_\_\_\_\_  
(Signature of parent, guardian, conservator/authorized) representative)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Student Counselor/Counselor)

#### NOTICE OF RECIPIENT INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure on this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. **DISCLAIMER: It is the legal responsibility of the recipient of this information (transmitted electronically or otherwise) to comply with HIPAA regulations.**