

**Nova Southeastern University
Student Counseling
Authorization for Use or Disclosure of Information**

I request and authorize Nova Southeastern University to:

- Release the following information to:
- Receive the following information from:

Name of Facility/Person: _____ _____
Address/City, State, Zip: _____ _____
Telephone No.: () _____
Fax No.: () _____

Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

This protected health information is being used or disclosed for the following purposes: (List specific purposes here; the client may indicate that the information to be disclosed is "at the client's request" if the client does not choose to provide an explanation of the purpose of the request.)

- Continued Care by other health care provider
- Insurance
- Attorney
- Disability
- University/College
- Personal Review
- Other (please specify)

I understand and agree that the information I am authorizing to be released may include:

- (1) Mental health information
- (2) Drug screen results and information about drug and alcohol use and treatment; and/or
- (3) AIDS/HIV test results, diagnosis, treatment and related information

Unless otherwise requested:

This authorization shall be in force and effect until: (Please complete one of the following)

Expiration of Authorization Date: _____

(Insert Expiration Date)

The happening of the following expiration event:

I understand that, as set forth in NSU's Notice of Privacy Practice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Douglas Flemons
Nova Southeastern University
Student Counseling
3301 College Avenue
Ft. Lauderdale, FL 33314

I understand that a revocation is not effective to the extent that the clinic has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that the clinic will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

Signature of Client or Personal Representative

Date

Print Name of Client or Personal Representative

Client Date of Birth

Description of Personal Representative's Authority

STATE OF _____

COUNTY OF _____

THE FOREGOING INSTRUMENT WAS SIGNED OR ACKNOWLEDGED BEFORE ME THIS
_____ DAY OF _____, 2007,

BY _____, WHO ARE PERSONALLY KNOWN TO ME OR WHO
HAVE PRESENTED _____ AS IDENTIFICATION,
AND WHO DID/DID NOT TAKE AN OATH.

NOTARY PUBLIC

SEAL: