Henderson Student Counseling Services

NSU Florida
CENTER FOR STUDENT COUNSELING AND WELL-BEING

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

I _____ **DOB:** _____ **SS#:** _____
Name of Student (PLEASE PRINT)

hereby give my permission to **Henderson Student Counseling Services** or to the entity listed below to release information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

To/From: _____
Name and Address of Person(s), Agencies, Organization to which information is to be released/requested.

Purpose of this release/request: _____

I authorize release/request of information covering treatment dates of: _____

The type of information to be disclosed/requested is as follows:

To Be Released	To Be Requested
_____ Treatment Plans	_____ Treatment Plans
_____ Progress Reports	_____ Progress Reports
_____ Health/Medical Records	_____ Health/Medical Records
_____ Education Reports	_____ Education Reports
_____ Discharge Summaries	_____ Discharge Summaries
_____ Psychological/Psychiatric Evaluations	_____ Psychological/Psychiatric Evaluations
_____ Social/Developmental History	_____ Social/Developmental History
_____ Verbal Communication	_____ Verbal Communication
_____ Other-	_____ Other

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Henderson Student Counseling Services.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Henderson Student Counseling Services will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Henderson Student Counseling Services.

____(initial) I understand that Henderson Student Counseling Services will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire twelve months from the date of signing and is subject to revocation in writing at any time.

Release:

_____
Student Signature **Date**

_____
Witness **Date**

Request:

_____
Student Signature **Date**

_____
Witness **Date**

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