Ottawa University
Prepare for a Life of Significance™

Counseling Center

Consent & Authority for Release of Confidential Information

I, ______________________________ born on ____________, consent to and authorize OUAZ Counseling Center, located at 15950 N Civic Center Plaza, Surprise, AZ 85374, phone: 623.233.7581

☐ To Release Information to: and/or ☐ To Obtain Information From:

Individual/Agency: ____

Relationship to Student: ____

Street Address: ____________________________ City: ________________ State:______ Zip:___________

Telephone Number: _________________________ Fax Number: _________________________

MENTAL HEALTH/MEDICAL INFORMATION TO BE RELEASED / REQUESTED:
I understand that this disclosure of my mental health/medical information will include the information about the following (if contained in my medical records, and if I check the "yes" box and initial below):

____ Yes **All** mental health records in my mental health file _______Initials

____ Yes **Only** the following indicated document(s):

___ Intake assessment ___ Treatment plan ___Clinical service notes __Discharge summary

___ Attendance ___ Participation ___Other: _____________________ _______Initials

____ Yes Screening and recommendations for further drug and alcohol abuse evaluation _______Initials

I authorize **__Verbal disclosure** of treatment information and/or **__Written disclosure** of treatment information

The records released/requested are being used for the purpose of:

- ☐ Coordination of Care
- ☐ Compliance with conditions of conduct, policy/procedure(s) violation(s)
- ☐ Referral to Another Agency
- ☐ Assist in Disability Determination Process
- ☐ Other specific reason(s):_______________________________________

Dates of services: __ Past 12 months __ Fall/Spring semester of ___ year __ Past 30 days __ Other__________

I understand the treatment information will only be used as described in this authorization. I am also aware that if I choose to share the information defined in this authorization with anyone not directly involved in the use or disclosure described above, HIPAA will no longer protect this information. I understand that I have a right not to authorize the use/disclosure of my medical/mental health information. In such a case, I would choose not to sign this authorization document.
This information may be protected by Federal and State Law. I further understand that the Ottawa University Counseling Center, shall only release this information to the agency or person named above. I also understand that if the person or entity that receives the information is not a health care provider or health plan covered by Federal or State Privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that any event this consent expires automatically in one year. I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

____ _________________
(Signature of Student / Legal guardian) Date

____ _________________
(Signature of Counselor) Date

PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose.

**Authorization Revoked Signature: __________ Date: __________