

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name: _____ DU ID # _____

Date of Birth: _____ - _____ - _____ Contact Phone Number: (_____) _____ - _____

I authorize University of Denver, Health and Counseling Center to:

Release/Request the following information: TO FROM Both TO and FROM

Please check ALL that apply:

- | | |
|--|---|
| <input type="checkbox"/> DU Athletics Department | <input type="checkbox"/> DU Disability Services Program (DSP) |
| <input type="checkbox"/> DU Student Outreach and Support (SOS) | <input type="checkbox"/> DU Student Rights and Responsibilities (ORR) |
| <input type="checkbox"/> DU Learning Effectiveness Program (LEP) | <input type="checkbox"/> DU Housing and Residential Education (HRE) |
| <input type="checkbox"/> DU Graduate Studies | <input type="checkbox"/> DU International House (I-House) |
| <input type="checkbox"/> DU Financial Aid | <input type="checkbox"/> DU Care Team |
| <input type="checkbox"/> Other (specify): _____ | |

(MEDICAL RECORD)

- Medical Data/Information related to:
- | | |
|---|--|
| <input type="checkbox"/> Visit type/date: _____ | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Laboratory Tests (dates) _____ | <input type="checkbox"/> HIV/AIDS testing result |
| <input type="checkbox"/> Gynecological, i.e. pap smears (dates) _____ | <input type="checkbox"/> Other (specify): _____ |
- Verbal Communication only
- | | |
|---|---|
| <input type="checkbox"/> Medical Services / Treatment | <input type="checkbox"/> Other (specify): _____ |
|---|---|
- Support letter

(MENTAL HEALTH /COUNSELING/PSYCHIATRY RECORD)

- Verbal Communication (specify): _____
- Psychiatric/medication management treatment notes: (covering what dates-specify): _____
- The client's mental health record generated in this office (indicate specifics in the box below)

The following information will not be released unless you specifically authorize it by checking the relevant box(es) below:

- Support letter
- information pertaining to mental health visit attendance (dates/number of visits)
- information pertaining to mental health treatment notes (session notes/documentated contacts)
- information pertaining to treatment summary (closing summary—includes number of sessions, diagnosis, focus of treatment, treatment progress)
- information pertaining to psychological assessment

Purpose of Disclosure: (check one or more)

- | | | | |
|---|---|---------------------------------|--------------------------------|
| <input type="checkbox"/> Health Care / Continuity of Care | <input type="checkbox"/> Insurance / Billing | <input type="checkbox"/> School | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Employment/Internship | <input type="checkbox"/> Other (specify): _____ | | |

This authorization is valid for the academic year for the date signed unless a shorter time is indicated here: _____

You may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified, except to the extent disclosure made prior to receipt. Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected under Federal Privacy Regulations. DU Health and Counseling Center cannot require you to sign this Authorization as a condition to the provision of services; however, your care may be affected if your providers are not able to obtain information pertinent to your condition and treatment. You have a right to request a copy of this Authorization after signing it, and agree to pay reasonable copying fees (in compliance with Colorado statute) if records are not being sent to another medical/mental health facility.

Signature of Patient or Legal Representative

Date Signed