

THE UNIVERSITY OF
MEMPHIS.

Division of Student Affairs
Center for Student Development

206 Wilder Tower
Memphis, Tennessee 38152-3520

Office: 901.678.2067
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C.S.D. Psychological Counseling Unit and Career Counseling Unit

Details for Release of Information Consent Form

I, _____, _____, _____
print name ss# phone #

authorize _____
(name of counselor and department)

- to: ___ [send] / ___ [receive] :
- Verification of Attendance *only*
 - Psychological Treatment Summary
 - Psychological Treatment Status Report
 - Report of Psycho-Educational Evaluation
 - Report of Psychological Evaluation
 - Report of Career Testing or Evaluation
 - Other (specify) _____

___ [to] / ___ [from] :

_____ address
name

_____ phone # fax #
city, state/zip

This authorization expires _____

**A Tennessee Board of Regents Institution
An Equal Opportunity/Affirmation Action**

A Tennessee Board of Regents Institution
An Equal Opportunity - Affirmative Action University

Please be sure the information required on the back of this form is completed.

Client Release of Information Authorization and Disclosure of Health Care Information Form

(This form when completed and signed by you authorizes the Center to release protected information from your clinical record. Further information is printed on the back of this Authorization form.)

I, _____ SS# _____
(please print your name)

authorize my psychologist/counselor and/or the manager for the Center for Student Development (C.S.D.) to release protected health information to carry out treatment and obtain additional treatment authorization.

This authorization shall remain in effect either one year following treatment or until date specified on back.

I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Center's office address or completing a Revocation of Authorization Form available upon request. However, my revocation will not be effective to the extent that my counselor has taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist/counselor generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signature of Client

Date

Signature of Witness

Date

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the patient must be provided.

Personal Representative's Name

Relationship to Client

Disclosure of Health Care Information

I, _____, have had the opportunity to review the contents of the Center for Student Development's Tennessee Notice Form: Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information, effective April 14, 2003.

Signature: _____

Date: _____

Please be sure the information required on the back of this form is completed.