

COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)-INDIANA UNIVERSITY HEALTH CENTER
AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION
(If in couple's treatment, separate release required from each partner)

ID Number _____ Name _____ Date of Birth ____/____/____ Address _____ _____ Phone _____	REQUESTOR/RECIPIENT <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Client Attorney <input type="checkbox"/> Instructor <input type="checkbox"/> Family <input type="checkbox"/> Third Party Attorney <input type="checkbox"/> Other _____ Name _____ Address _____ _____ Phone (daytime) _____ Fax _____
---	---

DATES OF SERVICE FOR WHICH RECORDS ARE REQUESTED: _____

INFORMATION TO BE DISCLOSED (check all that apply):

<input type="checkbox"/> Full and complete <input type="checkbox"/> Summary of previous mental health treatment <input type="checkbox"/> Periodic reports of current treatment progress including attendance and participation	<input type="checkbox"/> Billing information <input type="checkbox"/> Other: _____ _____
--	--

PURPOSE OF DISCLOSURE (check all that apply):

<input type="checkbox"/> To develop a diagnosis and treatment plan or continuity of care <input type="checkbox"/> To coordinate medical and psychological care <input type="checkbox"/> Legal proceedings <input type="checkbox"/> To process insurance claims	<input type="checkbox"/> Confirm attendance <input type="checkbox"/> Other: please describe _____ _____ _____
---	--

AUTHORIZATION IS GIVEN TO:

Release information FROM CAPS
 Release information TO CAPS
 Release and request information FROM AND TO CAPS

INDICATE SPECIFIC INFORMATION TO BE EXCLUDED FROM THIS AUTHORIZATION, IF ANY (CHECK ALL THAT APPLY):

Drug and Alcohol Records
 HIV/AIDS records

I understand that my records are protected under state and federal confidentiality statutes and/or regulations, and that the information used or disclosed may be subject to re-disclosure by the person(s) receiving it and no longer protected by the federal privacy regulations. I further understand that these records will not be disclosed without my written authorization unless otherwise allowed by state or federal statute, rule or regulation. I authorize the use of a photocopied, faxed or scanned presentation of this form as a valid original for the release or disclosure of the information described above. I further authorize CAPS and its agents to utilize this authorization electronically.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from CAPS.

Authorization valid as long as I am in treatment with CAPS or if no longer in treatment 60 days from the date this form is signed.
 Other expiration date (date this release will expire): _____

I authorize the use or disclosure of my protected health information, either verbally, in writing, and/or facsimile, as described above:

Signature: _____ Printed Name: _____ Phone #: _____

Date: _____ Description of Representative's Authority to Act (if applicable): _____

Witness signature _____ Date _____

To Recipient of Client Records/Information:
 Information pursuant to this authorization has been disclosed to you from records which may be protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. The receiving organization/party is advised and should understand that some or all of the information provided pursuant to this release may not be re-released without the further consent of the client/patient except as allowed by statute, rule or regulation. The receiving organization/party will be solely responsible for any unauthorized disclosure or use.

Unless otherwise indicated, please send requested information to Counseling and Psychological Services (CAPS)
600 North Jordan Avenue, Bloomington, IN 47405
Telephone: 812 855-5711 Fax: 812 855-8447