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

[ ] Health Care Provider [ ] Client Attorney [ ] Instructor
[ ] Family [ ] Third Party Attorney [ ] Other_____

Name_____

Address_____

_____

Phone (daytime)_____Fax_____

DATES OF SERVICE FOR WHICH RECORDS ARE REQUESTED:_____

INFORMATION TO BE DISCLOSED (check all that apply):

[ ] Full and complete
[ ] Summary of previous mental health treatment
[ ] Periodic reports of current treatment progress including attendance and participation
[ ] Billing information
[ ] Other: _____

_____

PURPOSE OF DISCLOSURE (check all that apply):

[ ] To develop a diagnosis and treatment plan or continuity of care
[ ] To coordinate medical and psychological care
[ ] Legal proceedings
[ ] To process insurance claims
[ ] Confirm attendance
[ ] 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 statues 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

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