Counseling and Wellness Center
5800 Bay Shore Road
Sarasota Fl, 34243-210
Phone:941-487-4254
Fax: 941-487-4256

Authorization to Release of Confidential Information

Student's Name: ___________________________________ **Date of Birth**: _____________________
Student ID: _________________________________

By signing this form I understand that I am authorizing the Counseling and Wellness Center to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I hereby release the above parties from any legal liability for the release of this information.

Release to: ____________________________ **Obtain from**: ______________________________
(Name) (Name)

_______________________________________ ____
(Street Address) (Street Address)

____ ____
(City, State, Zip Code) (City, State, Zip Code)

____ ____
(Telephone Number, Fax Number) (Telephone Number, Fax Number)

________________________________ I understand that If requesting information relating to: (1) Acquired Immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; (3) mental or behavioral health or psychiatric care, excluding psychotherapy notes or (4) genetic testing, specific authorization on this form or a court order is required since this information is privileged.

I may revoke this authorization form at any time by notifying the Counseling and Wellness center, of my intent to revoke this authorization. Returning this form, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by New College of Florida, Counseling and Wellness Center before the College received my written notice of revocation. Otherwise, an official form for revocation will be given upon patient request. This authorization form expires in one year from the date signed below unless otherwise indicated.

I authorize release of information pertaining to (Check & Initial all that apply):

- ____ Treatment summary
- ____ Diagnosis
- ____ History/Intake
- ____ Medical Record
- ____ Dates of Treatment Attendance
- ____ Psychiatric Evaluation/Medical History
- ____ Other (please specify _________)

I grant permission for the staff at Counseling and Wellness center to release the above information from my medical, psychological and/or psychiatric records and to have reciprocal consultation regarding my treatment.

____ ___________________________
(Printed name of student) (Date)

____ ____________________________
(Signature of student) (Contact Telephone Number)

____ ___________________________
(Witness signature) (Date)

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Revocation section

I do hereby request that this authorization to disclose confidential information of __________________________
(Student Name)

Signed by ____ on __________________________________
(Name of Person Who Signed Authorization) (Date)

Be rescinded, effective _______________________. I understand that any action taken on this authorization prior to
(Date)
the rescinded date is legal and binding.

____
(Student Name)

____
(Student ID Number)

____
(Student Signature)

____
(Date)

____
(Witness signature)

____
(Date)