Authorization to Release, Exchange, or Obtain Information

I, _____ (client's full name; please print), authorize the University of Pittsburgh Health Center to:
_____ release, _____ exchange, _____ obtain
the following information:

_____ summary of previous counseling
_____ medical or hospitalization records
_____ psychological or psychiatric evaluation
_____ my condition in order to assist my treatment by conferring with
_____
_____ other (please specify):_____
_____

This information will be _____ released to, _____ exchanged with, _____ obtained from:
(Name and address of person and/or agency)
_____
_____
_____
_____ (Telephone) _____ (Fax)

I have been informed of my rights as a client, which appear on the other side of this form. My consent is given from the signature date of this document for 180 days.

I may revoke this authorization at any time by submitting a written statement directing the University Health Center to cancel this authorization.

Before signing, be certain that all blanks have been filled in.

x_____
(Signature of client) (Date)

_____
(Address)

_____
(Phone) (Pitt username)
____ / ____ / _____
(Date of birth)

_____
(Director of Student Health; please print)

_____
(Signature of Director of Student Health) (Date)

_____
(Signature of witness if client unable to sign) (Signature of witness if client unable to sign)

CLIENT'S RIGHTS
REGARDING SHARING OF INFORMATION

Before completing the authorization to have information released, exchanged, or obtained, please read the following:

You are eligible for health services whether or not you sign this form. If the University Health Center is requesting use of this form to obtain historical treatment information, please know the failure to sign this form, or another agency's release form, could affect the Health Center's ability to provide you with comprehensive care.

2. Your signature on this form authorizes the University Health Center to release, exchange or obtain information to/with/from only the person or agency named on the form.

3. You have the right to have the nurse explain what type of information will be released, exchanged, or obtained and have the right to examine that information before its release provided that it would not cause a substantial detriment to your treatment or violate third-party confidentiality rights.

4. You have the right to revoke this authorization at any time by submitting a written statement directing the University Health Center not to release, exchange, or obtain designated information. If unable to provide written revocation, an oral request is sufficient provided two persons witness the oral request. This authorization expires as specified on the other side of this form. Your decision to revoke the Authorization does not apply to any release of your health record(s) that may have taken place prior to the date of my request to revoke the Authorization.

5. There is a possibility that information disclosed pursuant to this authorization will be subject to redisclosure by the recipient and no longer be protected from disclosure by state or federal law.