Northwestern University

Counseling and Psychological Services

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Client Name ______ Date of Birth ______

Address ______ Phone ______

I AUTHORIZE NORTHWESTERN UNIVERSITY COUNSELING AND PSYCHOLOGICAL SERVICES TO EXCHANGE INFORMATION WITH:

(If an individual, describe the relationship to the patient)

Name ______

Address ______

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORD:

Please check off appropriate box(es)

- ☐ Psychiatric/Psychological
- ☐ Alcohol/chemical substance
- ☐ Medical
- ☐ Psychotherapy notes
- ☐ Lab reports
- ☐ HIV
- ☐ Termination summary
- ☐ School/education history
- ☐ Other ______

Purpose/need for information (specify the use of the information to be disclosed): coordinating care

THE FOLLOWING STATEMENT APPLIES ONLY TO RECORDS RELATING TO MENTAL HEALTH TREATMENT

I understand that my refusal to authorize disclosure of the above-mentioned information will prevent disclosure of information. The consequence of refusal to authorize may include incomplete diagnostic evaluation, recommendation or treatment. Additional consequences of refusal to authorize may be:

I understand this content is valid for one year from the date of signature. I may revoke this authorization at any time by giving written notice to Northwestern Counseling and Psychological Services (CAPS) except to the extent that CAPS has already acted in reliance on this contract. I understand I have the right to review and obtain the information to be disclosed. I authorize CAPS to use e-mail or other internet based communication to share information with authorized parties. I understand that information disclosure pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

______

Signature of client or authorized legal guardian date

______

Relationship to client, if signed by authorized representative

______

Signature of witness date

Authorization to fax records – Per CAPS policy, use of faxed records is limited to use by CAPS provider for coordination of client care only.

MUST USE BLACK BALL POINT PEN