

Authorization for Release/Obtaining of Student Mental Health Information

Student Name _____ Today's Date _____
Student ID# _____ Date of Birth _____
Phone _____

I hereby request the release/obtaining of the following for the purpose of provision, coordination, or management of mental health or associated services:

- | | |
|---|--|
| ☐ Treatment Plan/recommendations | ☐ Psychiatric Evaluation |
| ☐ Intake Assessment | ☐ Psychological Assessment Report |
| ☐ Progress Notes | ☐ Attendance Record |
| ☐ Treatment Summary | ☐ Medication Record |
| ☐ Crisis Session Notes | ☐ Substance Use Record |
| ☐ HIV/AIDS Record | ☐ Bates Record: Conduct Concern |
| ☐ Bates Record: Alcohol, Tobacco, and Other Drug Concern | |

Other (Please Specify) _____

Exceptions to Release of Information* _____

*Treatment records regarding substance abuse and HIV/AIDS are protected under Federal regulations. You have the right to refuse to release this information. All other information regarding mental health treatment may be withheld or limited, except as allowed or required by law. Limiting information may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.

This release of information is between Bates Counseling and Psychological Services and the following individual(s)/agency/organization:

Name(s) _____
Phone _____ FAX _____
Email _____
Address _____

☐ **Obtain Records/Information***

☐ **Disclose Records/Information***

*It is assumed that communication of information is permitted via phone, email, regular mail, verbally, fax, and/or in person **unless** limited by the client to one or more specific mediums.

By signing this authorization, I acknowledge:

This release of information is voluntary and I am not required to sign this form to receive any mental health services. This form will be retained as part of my treatment record at Bates Counseling and Psychological Services (CAPS). I may review and copy the information that is released upon request.

This release of information is authorized from ____/____/____ to ____/____/____. I may revoke this authorization at any time prior to its expiration date by written notice to either party to which disclosure has been authorized. Any such revocation will not have any effect on actions taken before the revocation.

I understand that health information held by CAPS is considered part of my "treatment record" under FERPA as a protected medical/mental health record and that by reviewing or disclosing this information, I am making it part of my "education record" under FERPA. This means that records I have reviewed or disclosed may be subsequently disclosed without my consent as authorized by FERPA.

I understand that CAPS may decline to disclose information if it is determined by the provider that such disclosure would be detrimental to my health. I will be notified if any such records are withheld.

I ☐ DO ☐ DO NOT want a copy of this authorization.

Signature of Student

Date

Printed Name of Student

Student ID

Witness