UMassAmherst
Center for Counseling
and Psychological Health

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AUTHORIZATION FOR RELEASE OF INFORMATION

When completed and signed by you, this form authorizes release of protected information from your clinical record to the recipient designated.

NAME:_____ DOB:_____ PHONE: _____

ADDRESS:_____

I authorize: _____
(Name of provider/facility/individual)

_____
(Address)

to release the following information *(describe information to be disclosed; be as specific and detailed as possible.)*:

_____

_____

_____

Release information to: _____
(Name of provider/facility/individual)

_____
(Address)

I am requesting that this protected information be released for the following reasons: *("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)* _____

_____

This authorization shall remain in effect until _____ *(specify date or event relating to purpose of disclosure)* at which time this authorization expires *(up to six months)*.

- ❑ **If this box is marked, I authorize the release of information regarding assessment, diagnosis and/or treatment of alcohol and/or substance abuse.**
- ❑ **If this box is marked, I authorize the release of information regarding diagnosis and/or treatment of AIDS or HIV.**

You have the right to revoke this authorization at any time by sending written notification to the office address. However, your revocation will not be effective to the extent that action has been taken in reliance on the authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

There may be a service charge for copying of records.

_____ _____ _____ _____
Patient signature Date Parent/Guardian signature Date

_____ _____
Witness signature Date