CREIGHTON UNIVERSITY STUDENT COUNSELING SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this form, you permit Creighton University Student Counseling Services to release your records described below.

A. **Client**. The person whose information may be released is:

NAME _____ **DOB** _____

ADDRESS _____ **NET ID** _____

B. **Records**. I am authorizing release of the following information (check as applicable):

__ Dates of Service __ Treatment Summary __ Other: _____
__ Assessment Report(s)

_____

C. **Special Instructions**.
___ Please release / ___Please DO NOT release drug and alcohol testing or treatment information, if any.
___ Please release / ___ Please DO NOT release HIV/AIDS test results, if any.
___Please release / ___ Please DO NOT release information regarding mental health treatment, if any.

D. **Recipients**. I give permission to Creighton to release the above records to:

NAME _____

ADDRESS _____

_____

FAX _____

CU E MAIL_____

NAME _____

ADDRESS _____

_____

FAX _____

CU E MAIL_____

E. **Permission to Communicate**. I permit Creighton University Student Counseling Services and the agencies listed in Section D to communicate regarding my treatment and records. The communication may include regular meetings regarding my ongoing treatment.

F. **Purpose of Release**. The reason I am authorizing release is:
___ My Request __ Accommodations ___ Attendance ___ Continuity of Care ____: Other _____

G. **Expiration**. This authorization expires:_____. If no date is listed, then this expires six months from the date listed below.

H. **Explanation of Rights**. I, as the patient/patient representative, understand that:

- I have the right to revoke this authorization at any time. I must give my written revocation to: Creighton University, Attn: University Privacy Officer, 2500 California Plaza, Omaha, NE 68178. Revoking this authorization does not affect disclosures already made by Creighton or disclosures otherwise required by law.
- I have the right to review my counseling record before signing this authorization. Creighton's Notice of Privacy Practice explains how to request access to my health record.
- I am authorizing disclosure of information protected by state law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state law.

I. **Authorization**. I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY COUNSELING INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____
Signature of Client/ Personal Representative Date

_____ _____
Representative's Relationship to Client (if applicable) Representative's printed name