

Psychological Services Center

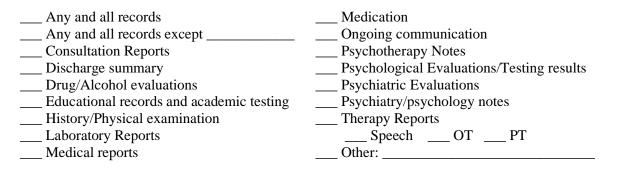
## DREXEL UNIVERSITY

## AUTHORIZATION TO DISCLOSE HIGHLY CONFIDENTIAL INFORMATION

Client Name:	Date of Birth:
Address:	
Phone:	
I hereby consent and authorize:	
Name of Person or Organization:	
Address:	
Phone Number:	Fax Number:
To release and disclose medical information to:	
Name of Person or Organization:	
Address:	
Phone Number: Fa	ay Number
I wish for this release to be <b>bidirectional</b> so that be with one another.	oth persons/organizations can share the information
YesNo	
For the purpose of:	
For the following dates of service:	

Please release these records via \_\_ Fax\_ Copy/Mail \_\_ Telephone. I understand that depending on the volume of materials and/or potential confidentiality issues, it may not be possible for records to be faxed. In these cases, the records will be copied and mailed.

Initial next to information that may be disclosed/released:



I have been informed and understand that this authorization, except for action already taken, may be voided by me at any time. I am further aware that, unless ended, this authorization to release information will expire on the date indicated below, a period of time not to exceed one year.

This office generally may not condition services upon my signing an authorization, unless the services are research-related or for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule.

This authorization is effective from \_\_\_\_\_\_ to\_\_\_\_\_ and has been fully explained to me, and my signature certifies that I understand its contents.

Printed name of Client	Date	
Signature of Client	Date	
Printed name of Legal guardian/Parent/ Authorized representative	Date	
Signature of Legal Guardian/ Parent/ Authorized Representative	Date	
Printed name of Practice Representative	Date	
Signature of Practice Representative	Date	

This authorization to disclose highly confidential information has been rescinded on:

Date

Printed name of Client	Date	
Signature of Client	Date	
Printed name of Legal guardian/Parent/ Authorized representative	Date	
Signature of Legal Guardian/ Parent/ Authorized Representative	Date	
Printed name of Practice Representative	Date	
Signature of Practice Representative	Date	

The form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, as explained in the Notice of Privacy Practices presented at patient registration by the Drexel PSC office staff. The form also complies with applicable Federal and applicable State Law.