WILLIAM PATERSON UNIVERSITY
COUNSELING, HEALTH & WELLNESS CENTER
OVERLOOK SOUTH
(973)-720-2360 · (973)-720-2257 · FAX: (973)-720-2632
300 POMPTON ROAD · WAYNE, NEW JERSEY 07470-2103 · WWW.WPUNJ.EDU

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form when completed and signed by you, authorizes The Counseling, Health & Wellness Center to release protected information from your clinical record to the person or agency you designate

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1) I hereby give permission to: □ Counseling □ Health & Wellness

2) To disclose the protected health information of:

Student's Name: _____ Student ID: 855_____

Date of Birth _____ Contact Phone #: _____

3) Name of person or organization to release, obtain, or discuss the protected health information:

□ Release information to: _____

□ Obtain information from: _____

□ Discuss information on an ongoing basis with: _____

4) The records are to be:

□ Picked up by: _____

□ Mailed to Address/City/State/Zip: _____

□ Emailed to: _____

□ Faxed to #: _____

□ Phone Release to #: _____

5) Purpose of disclosure (check all that apply:

□ Further health care □ Verification of attendance □ Further mental health evaluation/treatment

□ Legal investigation □ Payment of insurance claim □ Planning and/or coordination of ongoing care

□ Personal use □ Academic accommodations

□ Other: _____

HEALTH & WELLNESS INFORMATION TO BE DISCLOSED: *(turn page over for counseling options)*

Please check the appropriate sections of the health record to be released (check all that apply):

□ Records only related to the following date(s) of service: _____

□ Record of attendance at appointments □ Specific Lab and/or Radiology Results: _____

□ Immunizations □ Most Recent Gynecological Exam/Pap smear

□ All Medical Note(s)*** □ Specific Medical Notes: _____

□ Records which may indicate the presence of a communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS treatment, testing, or discussion_____(initial).

***Please note that an authorization for the release of **all Medical Notes** may disclose sensitive information about your **mental health, drug or alcohol use, episodes of domestic violence or sexual assault, and history or treatment for Sexually Transmitted Infections.**

COUNSELING INFORMATION TO BE DISCLOSED:

Please check the appropriate sections of the mental record to be released (check all that apply):

□ Attendance Confirmation on the Following Date(s): _____

□ Intake Assessment – Written Summary Psychiatric

□ Evaluation/ Treatment/ Treatment Planning – Written Summary

□ Psychological Counseling Evaluation/ Therapy – Written Summary

□ Termination Summary

□ Alcohol/ Drug Information – Written Summary

□ Sexual Assault Information

□ Verbal Summary Information

□ Other: _____

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6) Any Other Instructions about Information Released:

_____

_____

_____

I understand that my health records are protected under N.J. regulations applicable to physicians and other health care professionals. I also understand that my records are protected under the Federal Protected Health Information regulations. I have the right to review my medical records except in specific limited circumstances, and to request amendments where appropriate.

My health information may be subject to re-disclosure and not protected by Federal or State Statutes in the occurrence of a medical emergency, reporting of communicable disease as required under NJ Public Health statutes, disclosure in response to a subpoena duces tecum or court order, or required disclosure to a government agency. Specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals, and/or a history of testing or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

This authorization shall remain in effect for one year from date signed below or *(alternate end date)* :_____
I understand that I may revoke this authorization at any time by notifying William Paterson University Counseling, Health & Wellness Center (CHWC) in writing, except that revocation will not cancel any action taken by CHWC upon the original Authorization for Disclose Protected Health Information.

►**Student Signature:** _____ **Date** _____

(Signature Required)

***Representative's Signature** *(if student is unable to sign)*:** _____

Print Representative's Name: _____ **Date** _____

*If the authorization is signed by a representative of the student, relationship to student or a description of such representative's authority to act for the student must be provided: _____

FOR STAFF USE ONLY

► **Witness Signature** _____ **Date** _____

(Staff Signature Required)

Records Release Completion

□ Records copied and faxed as requested □ Records copied and mailed as requested □ Records copied and emailed as requested

□ Records copied and given as requested to person(s) indicated above □ Other _____

Completed by: _____ Date: _____