Center for Health and Counseling
CREIGHTON UNIVERSITY

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION

The Center for Health and Counseling (CHC) must obtain a written authorization from a patient or their personal representative prior to releasing confidential health and counseling information, unless a legal exception applies.

PATIENT INFORMATION

I hereby authorize CHC to release confidential health and/or counseling information of the patient listed below.

Name:____
DOB (MM-DD-YYYY):____________________________ NET ID:______________________ Phone:________________________________
Address: ____

RECIPIENT/SENDER INFORMATION

☐ Deliver Records **FROM** Center for Health and Counseling ☐ Deliver Records **TO** Center for Health and Counseling	Name:____ Address:____ Phone:____ Fax:____

Please send my records by: ☐ Fax ☐ Mail ☐ I will pick up in person at CHC

Purpose of release: ☐ Treatment/Continuity of Care ☐ Accommodations ☐ Attendance ☐ Personal Use ☐ Legal

SPECIFIC TREATMENT PERIODS

Specific treatment date or time period for which the information is requested:

- ☐ Single treatment date of___________________________________
- ☐ Period of treatment from_____________________________to____________________________
- ☐ Any and all treatment encounters to date.

MEDICAL INFORMATION TO BE DISCLOSED	MENTAL HEALTH INFORMATION TO BE DISCLOSED
☐ My Complete Medical Record ☐ Include records from outside medical providers/facilities ☐ Progress Notes/History & Physical ☐ Radiology Reports ☐ Lab Results ☐ Other___________________________________	☐ Counseling Treatment Summary ☐ Dates of Service (Attendance Only) ☐ Counseling Assessment Report(s) ☐ My Complete Counseling Record ☐ My Complete Psychiatric Record ☐ Other___________________________________

ADDITIONAL AUTHORIZATION REQUIRED

I authorize, the release of the following types of records. ☐ Treatment for Alcohol and/or Drug Abuse ☐ HIV/AIDS ☐ Mental Health (within Medical Records)	**NOTE:** Patients who believe these record types do not pertain to them may still choose to authorize release to expedite the record release process. If you choose not to authorize, your record must be reviewed in detail to determine if these record types are present. This review and redaction process can take up to 30 business days.

I understand that:

1. I have the right to revoke this authorization at any time by notifying Creighton University Center for Health and Counseling in writing. If not revoked earlier, this authorization will expire in one year. Revoking this authorization does not affect disclosures already made by Creighton or disclosures otherwise required by law.
2. I have the right to review my health/counseling record before signing this authorization. Creighton's Notice of Privacy Practice explains how to request access to my health/counseling record.
3. There may be a fee associated with the copying of records.
4. I am authorizing disclosure of information protected by state law. This information, once disclosed, may be subject to redisclosure by the recipient and no longer be protected by state law.

SIGNATURES

I have read the above and authorize the disclosure of the confidential health information as stated.

Signature of Patient/Personal Representative:	Date:
Print Name of Patient's Personal Representative: (if applicable0	Relationship to Patient

Creighton University
Center for Health and Counseling

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