DREXEL UNIVERSITY
Department of
Psychological and
Brain Sciences
College of Arts and Sciences

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: _____ Fax Number: _____

I wish for this release to be **bidirectional** so that both persons/organizations can share the information with one another.

_____Yes _____No

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:

___ Any and all records
___ Any and all records except _____
___ Consultation Reports
___ Discharge summary
___ Drug/Alcohol evaluations
___ Educational records and academic testing
___ History/Physical examination
___ Laboratory Reports
___ Medical reports
___ Medication
___ Ongoing communication
___ Psychotherapy Notes
___ Psychological Evaluations/Testing results
___ Psychiatric Evaluations
___ Psychiatry/psychology notes
___ Therapy Reports
___ Speech ___ OT ___ PT
___ Other: _____

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.