Pittsburg State University
University Counseling Services
Consent for Release of Information

UNDER HIPAA REGULATIONS, THIS RELEASE IS ONLY VALID IF ALL BLANKS ARE FILLED IN.

Patient's Name: _____

Address: _____ _____ _____ _____

Birth Date: _____ **Telephone Number:** _____

PSU ID #: _____

I HEREBY AUTHORIZE PSU: ☐ **UNIVERSITY COUNSELING SERVICES** ☐ **Release To** ☐ **Obtain From:**

Name of Individual or Agency: _____

Address: _____ _____ _____ _____

Telephone Number: _____ **Fax Number:** _____

THE FOLLOWING INFORMATION IS REQUESTED:

Dates of Service: **From:** _____ **To:** _____

☐ Summary of Treatment: Dates of contact, intake, progress notes, treatment plan, diagnosis, prognosis, closing summary, recommendations, current needs, and functioning level.

☐ Telephone Consultations ☐ Medical Records

☐ Psychological Evaluation/Testing ☐ School report regarding grades, standardized tests, and conduct.

☐ ADHD/Learning Disabilities ☐ Other: _____

ADDITIONAL INFORMATION REQUESTED:

☐ AIDS/HIV Status

☐ Alcohol and Drug Treatment

THE REQUESTED INFORMATION WILL BE USED FOR (CHECK ONE OR MORE BELOW):

☐ Coordination of Services/Treatment Planning ☐ Legal Counsel ☐ Insurance

☐ Other: _____

I understand that once the uses/disclosures have been made as permitted by this form, the records/information may be subject to re-disclosure and no longer protected by federal privacy regulations. I understand that I may refuse to sign this authorization and that will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by delivering in writing a revocation to Pittsburg State University, University Counseling Services and/or Center for Student Accommodations, but if I do, it will not have any effect on actions the Center took in reliance on this authorization prior to receiving the revocation. I authorize the use/disclosure of the records/information described above.

Specify the date or condition upon which this consent expires: _____
(not to exceed one year)

_____ _____ _____
Patient signature (or parent, guardian or authorized representative) Relationship to Patient Date

_____ _____
Witness Date

****PREPAYMENT OF CHARGES FOR DUPLICATION OF RECORDS IS REQUIRED****
Please allow ten business days for processing

Charges: $ _____ Date Sent: _____
Reviewed by: _____
No charges if records sent to a health care provider

Records Requested by: _____

Pittsburg State University – University Counseling Services
1701 S Broadway, Pittsburg, KS 66762
PHONE NUMBER: 620-235-4452 FAX NUMBER: 620-235-6146