UNC GREENSBORO
UNCG Psychology Clinic

AUTHORIZATION FOR REQUEST AND DISCLOSURE OF CLIENT INFORMATION

Client Name: _____ Date of Birth: _____
Last First Middle Initial

By signing this Authorization Form, I understand that I am giving my authorization to the UNCG Psychology Clinic to request and/or disclose my protected health information (PHI), as described below, to the following person(s) or organization(s):

____ Obtain my information from: **____ Disclose my information to:**

Name of person(s) or organization(s): _____

Street address, city, state, and zip code:_____

Telephone number:_____ Fax number: _____

I specifically authorize the UNCG Psychology Clinic to request and/or disclose the following information:

_____ Reason for referral _____ Treatment summary _____ Academic records/teacher evaluations

_____ Any social, medical, psychological, psychoeducational, or psychiatric evaluation report

_____ Diagnosis or diagnoses, types of psychological services provided, and dates of psychological service provision

_____ Currently prescribed medications and medication history

_____ Other (please describe in detail): _____
_____

I am authorizing the clinic to request and/or disclose this information for the following reasons:

_____

I understand the contents to be requested and/or disclosed and the need for this information, and that there are statutes and regulations governing the confidentiality of this information. I hereby acknowledge that this authorization is voluntary and is valid until the request is filled, and, unless earlier revoked, will automatically expire 365 days after it is signed.

Confidential information may be released WITHOUT your permission if:

- You threaten to harm yourself or someone else and your threat is believed to be serious, your counselor is ethically and legally obligated to take whatever action seems necessary to protect you or others from harm.
- There is suspected child abuse or neglect to a minor or elder. Counselors are obligated by law to report this to the appropriate state agency. This law also applies if you report that you have reason to believe another person is abusing or neglecting a child or elder. If you are involved in litigation of any kind and inform the court of the services you receive here, you may be waiving your right to keep your records confidential.
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I further acknowledge that I have the right to revoke this authorization at any time by notifying the UNCG Psychology Clinic of my intent in writing or by completing and signing a UNCG Psychology Clinic “Revocation of Authorization to Request/Disclose Protected Health Information (PHI)” form; however my revocation will not be effective to the extent that the Psychology Clinic has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that I am not required to sign this Authorization form in order to receive psychological services from the UNCG Psychology Clinic unless the psychological services are provided to me for the purpose of creating health information for a third party.

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Redisclosure

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C-51 through 122C-56), substance abuse treatment information protected by federal law (42 C.F.R. Part 2), and information relative to individuals with AIDS or related conditions protected by state law (G.S. 130A-143), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these three laws. Our Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

– OR –

Client _____ Date _____

Legally Authorized Representative _____ Relationship to the client giving representative authority to act for client (*if applicable*) _____ Date _____

Witness _____ Date _____