University of Northern Colorado Counseling Center
Greeley, Colorado 80639 - (970) 351-2496 Fax: (970) 351-1485

Authorization for use or disclosure of protected health information

Purpose: In order for the UNC Counseling Center to provide beneficial service to its clients, it is often necessary to communicate with other people or agencies with whom you have or had contact. Your signature on this form gives UNC's Counseling Center permission to contact the individual(s) or agency(ies) named and for the individual(s) and/or agency(ies) to share the information for which you have authorized release. Any other sharing of information gained during our contacts is expressly prohibited except in a situation where disclosure is ethically or legally required.

I, _____ hereby authorize the UNC Counseling Center and its staff to:
Last name First name ◯ release to ◯ receive from ◯ exchange with

_____
Name of individual or agency Address Phone

Information to be Disclosed:
◯ Coordination of Care and Release of Pertinent Information
◯ Psychiatric Records
◯ Other (List): _____

Purpose of the Disclosure:
◯ Continuity of Care
◯ Legal
◯ Personal
◯ Other (List): _____

I understand that this authorization by me is subject to revocation at any time with respect to future disclosure of information. I understand that any revocation by me will not affect any releases made or other action taken previously in reliance upon an authorization I have given and prior to receiving my revocation and that any information so released may no longer be protected by federal or state law. I understand that my revocation must be in writing and addressed to: ***UNC Counseling Center, Campus Box 17, Cassidy Hall, University of Northern Colorado, Greeley, Colorado 80639.***

If not previously revoked, this authorization will be terminated one year after the date on which I signed it.
Date authorization expires (If different from one year to date of signature): _____.

_____ _____
Signature of Client or Personal Representative **DOB/Bear Number** **Date**

_____
Print Name of Client or Personal Representative Authority

_____
Client Phone Number

_____
Witness Signature **Date**

NOTE TO RECEIVER: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2.) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.