



**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.*

In order for the UNC Counseling Center to provide maximally 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 person(s) or agency named 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, its administrative and clinical staff to:

\_\_\_\_\_ Last name First name

release to  receive from  exchange with

\_\_\_\_\_ Name of individual or agency Address Phone

- Intake summary, treatment plan, treatment progress summaries, and/or termination summary
- Confirmation of and dates of service
- DSM-IV-TR diagnosis and/or medical diagnosis
- Other (List): \_\_\_\_\_

Initials

This protected health information is being used or disclosed for the following purpose(s).

- Ongoing Medical Care or
- Other (List): \_\_\_\_\_
- The client has requested this information be used and disclosed but does not wish to specify the purpose.

Initials

I understand that my chemical dependency records are protected under Federal regulations, 42 CRF, Part and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I give my permission to include information regarding the following condition (s) in the information released or requested: (Note: Information regarding the below listed conditions should only be released or requested if the appropriate box is marked.)  Drug abuse, if any  Alcoholism or alcohol abuse, if any

Initials

**I do not give my permission to release information regarding the following:** \_\_\_\_\_

**This authorization shall be in force and in effect for one year to the date of the clients's signature on this form at which time this authorization to use or disclose this protected health information expires.**

Date Authorization Expires (If different from on year to date of signature): \_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

*Privacy Official of University Counsel  
 Campus Box 29  
 4003 Carter Hall  
 University of Northern Colorado  
 Greeley, Colorado 80639*

**I understand that a revocation is not effective to the extent that my health care provider has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization.**

**I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may not longer be protected by federal or state law.**

\_\_\_\_\_  
Signature of Client or Personal Representative

\_\_\_\_\_  
S.S Number/Bear Number

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Print Name of Client or Personal Representative Authority

\_\_\_\_\_  
*Description of Personal Representative's Authority and attach document evidencing authority, such as a Power of Attorney*

\_\_\_\_\_  
Client Phone Number

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date: