CONNECTICUT COLLEGE STUDENT COUNSELING SERVICES
270 MOHEGAN AVENUE, NEW LONDON, CT 06320 (860) 439-4587
AUTHORIZATION TO DISCLOSE / OBTAIN PROTECTED HEALTH INFORMATION
ALL LISTED INFORMATION IS REQUIRED AND MUST BE FILLED IN

Subject to the statements printed below, I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

Name _____ Date of Birth _____

Fill out this section for Connecticut College Student Counseling Services to disclose:
I authorize the Connecticut College Student Counseling Services to disclose mental health information to:
Name: _____ Facility: _____
Address: _____
Telephone: _____ Fax: _____ Method: [ ] Mail [ ] Verbal [ ] E-Mail [ ] Fax

Fill out this section for Connecticut College Student Counseling Services to obtain:
I authorize _____ to disclose mental health information to Connecticut College Student Counseling Services.
Mailing address: Connecticut College, 270 Mohegan Avenue, New London, CT 06320. Contact Person: _____
Telephone: _____ Fax: _____

The dates of service and the type(s) of information to be used or disclosed are as follows:
Dates of treatment: _____ [ ] Medical/Clinical/Psychological/Psychiatric information [ ] Treatment plans, background information [ ] Psychological / neuropsychological/psychosocial assessment [ ] Lab reports [ ] HIV related information [ ] Exchange with Athletics [ ] All counseling records [ ] Other _____

The purpose of this disclosure or use is for the following reason:
[ ] Medical/Psychological treatment or follow-up [ ] Legal [ ] Disability [ ] Request of patient [ ] Medication management
[ ] Continuity of care [ ] Clearance for Athletics [ ] Other _____

I agree that a copy of this authorization will be as valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying the Connecticut College Student Counseling Services in writing, but if I do, it will not have any effect on actions taken before the revocation was received. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by Federal privacy regulations. I understand that my treatment or continued treatment by the Connecticut College Student Counseling Services is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

Patient Signature (or authorized representative*) _____ Date _____
*Note: If you are signing as the legally authorized representative of the patient, please indicate your relationship to the patient here:
[ ] Parent [ ] Guardian [ ] Other _____

HIV RELATED INFORMATION
In the event that information released constitutes confidential HIV related information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC/PSYCHOLOGICAL INFORMATION
In the event that information released constitutes confidential psychiatric/psychological information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS
In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (43 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.

MEDICAL RECORD
The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes Sec. 52-146o Connecticut General Statutes.