University of New Hampshire

Psychological and Counseling Services

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TTY: 7.1.1 or 800.735.2964 (Relay NH)
www.unh.edu/pacs

Authorization for Release/Request of Confidential Information

I, (Print Client Name)_____and (Print Client Parent or Legal Guardian Name if client is under 18 years old) _____ hereby give permission to UNH Psychological and Counseling Services to ☐ **release or** ☐ **request information for professional use.**

I understand that this authorization includes the release of psychological and/or psychiatric and/or mental health information which **may be part of the medical record.**

Person or organization to/from which information is to be released/requested (as noted above):

_____ Name

_____ Address

_____ Phone

_____ Fax ***Release of my records via FAX machine: I accept the risk of misdirected information via misdialed phone number and misdirected release within the receiving facility/company. **INITIAL** _____

Dates of Treatment (required) _____ to _____

Information to be Released

- ☐ Intake Report / Admissions Report
- ☐ Psychological Testing Report
- ☐ Confirmation of Dates of Service
- ☐ Complete record (other than sensitive information not initialed below)
- ☐ Other: _____

Reason for Release

- ☐ Continuity of Care
- ☐ Legal *(Note: Records may be re-released by recipient, as permitted by applicable law.)*
- ☐ Other: _____ (for example: client request, referral, consultation)

Specific Exception(s) to Release: _____

Sensitive Information to be Released (please initial items authorized for release)

_____ Drug and alcohol treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric evaluation and progress notes
_____ Therapy progress notes
_____ Treatment / discharge summary

This authorization expires in 1 year from the date signed, unless otherwise specified: _____.

I understand that once my records are released, they may be re-released by the recipient, beyond the control of Psychological and Counseling Services, and may no longer be protected by Federal or New Hampshire law. I understand that I may revoke this authorization at any time by notifying PACS in writing EXCEPT to the extent that action may have already been taken in reliance on my authorization. I understand that any records released to any other department or unit of the University of New Hampshire (other than Health Services) will become part of my education record under FERPA. I also hereby release the UNH PACS from any liability in connection with the release of the above information.

_____ Client Signature

_____ Date

_____ Print Name

_____ Date of birth

_____ Signature of Parents or Legal Guardians (If client is under 18 years old)

_____ Date

_____ Printed name of Parents or Legal Guardians