COUNSELING AND PSYCHOLOGICAL SERVICES | University of Nebraska Lincoln

Counseling and Psychological Services
University of Nebraska-Lincoln
550. N. 19th St., Suite 233
Lincoln, NE 68588-0618
Ph: 402.472.7450 Fax: 402.472.6977

RELEASE AND EXCHANGE OF INFORMATION AUTHORIZATION FORM

I, _____ DOB: _____ NUID: _____
(please print)

Current phone number: _____

I authorize Counseling and Psychological Services ☐ to release to -OR- ☐ to obtain information from:

_____
(Name of Person/Agency)

_____
(Street or P.O. Box)

_____
(City) (State) (ZIP)

_____
(Telephone) (Fax)

I authorize information to be released by all of the following methods:

☐ Mail ☐ Phone ☐ Fax ☐ Verbally ☐ Will pick up

Purpose of Disclosure: ☐ Coordination of care ☐ Referral ☐ Accommodations ☐ Other: _____

I authorize the disclosure of the following:

☐ I agree to whatever is needed to coordinate my clinical care **-OR-** ☐ I authorize only the following:

☐ Attendance dates ☐ Closing summary ☐ Diagnosis ☐ Intake ☐ Progress notes
☐ Substance Abuse Evaluation ☐ Other (specify): _____

☐ My consent to release and obtain information expires one year from the date of signature. **OR**
☐ I restrict my consent to the following dates: _____ to _____

FAX

☐ I understand that the security of information that is sent by fax cannot be guaranteed.

This statement of consent can be revoked at any time before disclosure of the information, and expires on _____ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation. I understand that the individual /institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations. I understand Counseling and Psychological Services at the University of Nebraska-Lincoln and its affiliates will not condition evaluation or treatment on whether I sign this authorization. Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

Student's signature: _____ Date: _____

Witness Signature: _____ Date: _____

Parent Signature (17 and under) _____ Date: _____