THE UNIVERSITY of MISSISSIPPI

COUNSELOR EDUCATION CLINIC FOR OUTREACH AND PERSONAL ENRICHMENT

# Request for an Individual's Health Information / Treatment Records and Authorization to Release

**Last:** **First:** **Middle:**

**Date of Birth:**

**Address:** **Home Phone: ( )**

X I hereby request access to the protected health information in my health record, covering the period from (date) _____ to (date) _____

[ ] Session Attendance Record
[ ] Treatment Issues
[ ] Discharge Summary
[ ] Other: _____

[ ] Recommendations
[ ] Treatment Plans
[ ] Diagnosis

[ ] Mail copies of my records to the individual noted below :

| Communication between | |
|---|---|
| Name: Counselor Education Clinic (Cope) | Name: |
| Address: 2301 S. Lamar Blvd. University, MS 38677 | Address: |
| Phone: 662-915-7197 | Phone: |
| Fax: 662-915-1363 | Fax: |

Purpose of Request: __patient's request, __ continuity of care, __referral, __other: _____

**I understand:**

- I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- For non-students, information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2) The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization 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. As a result, by signing below I specifically authorize any such records included in my health information to be released

| Signature of Patient, Parent, or Legally Authorized Representative | Relationship to Patient | Date |
|---|---|---|

| Signature of Witness | Print Name | Date |
|---|---|---|