THE UNIVERSITY OF ALABAMA

Client # _____

The University of Alabama Psychology Clinic

TITLE: AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below. Unless explicitly excluded, this Authorization includes any information relating to drug and/or alcohol abuse/treatment, communications with psychiatrists or psychologists, or records pertaining to sexually transmitted diseases, if they are a part of my health record. I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to redisclosure and may no longer be protected by federal privacy regulations.

Client Name: _____ Date of Birth: _____

Persons/Organizations providing the information:

_____
_____
_____
_____

Persons/Organizations receiving the information:

_____
_____
_____
_____

Specific description of information {including date(s)}: All dates of services indicated below.

____ Psychological Treatment/Therapy Summaries
____ Psychological Evaluation Report(s)/Information
____ Psychiatric Records
____ Other _____
_____ Grades/School Transcripts
_____ School Evaluation Report(s) and Information
_____ Medical Records

Release Information By: Mail: ( ) yes ( ) no Telephone: ( ) yes ( ) no Other: ( ) yes ( ) no
Fax: ( ) yes ( ) no Email: ( ) yes ( ) no

Purpose of Use or Disclosure: (individual may indicate "at the request of the individual")

_____
_____

Authorization Expiration Date or Event: _____

(NOTE: After this date or event has passed, this authorization to use/disclose will no longer be valid. Unless otherwise specified, an authorization will be valid for 6 months after the date it is signed. If authorization is for research purposes, the statement "end of the research study" or "none" or similar language will extend your permission beyond 6 months.)

The client or the client's representative must read and initial the following statements:

Initials: _____ I understand that I may revoke this Authorization at any time by notifying the Psychology Clinic in writing, but if I do, it will not have any effect to the extent the Psychology Clinic took action in reliance on the Authorization.

Initials: _____ I understand that the Psychology Clinic may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances:

a) participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research
b) initial enrollment in health plans can be conditioned on signing an Authorization for the health plan to review PHI to make eligibility determinations
c) furnishing healthcare services to me at the request of a third party can be conditioned on me signing an Authorization for disclosure of the PHI to the third party requesting the treatment.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name of Client and/or Representative and relationship: _____

Current Address: _____

Note: If client is age 14-18 both sign unless the 18 yr is a UA student and then the 18 yr signature is adequate.

6/21/2016