RELEASE OF INFORMATION - AUTHORIZATION OF DISCLOSURE

Ashland University Student Health Center
401 College Avenue • Ashland, Ohio 44805
Phone: 419.289.5200 • Fax: 419.289.5209

All matters relating to client records are considered confidential and are treated as such by the Student Health Center Staff. Information regarding such matters cannot be given without the consent of the client.

Client's Name _____

Date of Birth _____ **Social Security Number** _____

Ashland University Student Health Center is hereby granted permission to:
(full name/title, address, phone/fax number, institution or agent is requested)

Release to: _____

Exchange with: _____

Request from: _____

Purpose or need for disclosure: to secure appropriate information from or release appropriate information to the above named person or organization to assist in treatment planning for the client.

Extent and nature of information to be disclosed: the following circled information is requested to the fullest extent the requested person or organization can provide:

① Full Clinical Records ② History & Physical Form ③ Laboratory Reports

④ Finding & Treatment Sheets/Progress Notes ⑤ X-Ray Reports

⑥ Other (please specify) _____

This consent (unless revoked earlier) expires ninety (90) days from the date of authorization
I voluntarily consent to the disclosure of the above requested information. No threat or coercive measures have induced me to sign this consent form. I hereby further release you from all legal responsibility or liability that may arise from the act that I have authorized above.

Client Signature _____ **Date** _____

Witness Signature _____ **Date** _____

I have the right to STOP this release of information at any time. Although I understand that I cannot do anything about information I previously said could be shared, I now want no more information shared and I am withholding consent.

Signature of Client _____ ***Date*** _____

Notice: Prohibition on re-disclosure to anyone receiving information

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CRF Part I) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization form the release of medical or other information is not sufficient for this purpose.