University of Kentucky

**Counseling Center**
*Consultation and Psychological Services*
106 Frazee Hall, Lexington, KY 40506-0031
Ph: 859-257-8701 Fax: 859-257-3319 *www.uky.edu/counselingcenter*

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

**Client Name:______________________________ Date of Birth:_______ UKID#_____________**

**Authorization is hereby granted to the University of Kentucky Counseling Center to exchange relevant clinical information with:**

- ☐ **University Health Service**
  830 S. Limestone Street, Lexington, KY 40536-0582, 323-5511
- ☐ **Dean of Students Office** (incl. COC team)
  513 Patterson Tower, Lexington, KY 40506-0027, 257-3754
- ☐ **Violence Intervention & Prevention Ctr.** 406 Administration Dr., Lexington, KY 40506-0031, 257-3574
- ☐ **Office of Student Financial Aid**, 128 Funkhouser Building, Lexington, KY 40506-0054, 257-3172
- ☐ **Residence Life**, 537 Patterson Office Tower, Lexington, KY 40506-0027, 257-4784
- ☐ **Retroactive Withdrawal Committee**
- ☐ **Disability Resource Center**
  725 Rose St, Ste 407, Lexington, 40536-0029, 257-0082
- ☐ **UK HealthCare Good Samaritan Hospital**
  310 S. Limestone, 40508-8633, 226-7000
- ☐ **Jesse G. Harris, Jr. Psych Services Center**
  644 Maxwelton Court, Lexington, 40508-3225, 257-6853
- ☐ **James W. Stuckert Career Center**
  408 Rose Street, Lexington, 40506-0494, 257-2746
- ☐ **UK Athletics** Joe Craft Center, 338 Lexington Ave., Lexington, KY 40506-0604, 257-8000

Other person/ organization: ____________________________________________________________

Address: ________________________________________ Phone: _________________________

**I authorize the sharing of the following specially protected records:**

☐ Diagnosis, treatment, assessment, and/or consultation for mental health or psychiatric disorders

☐ Diagnosis or treatment of drug and/or alcohol abuse

☐ Diagnosis or treatment of AIDS and/or HIV

☐ Genetic testing, counseling, and education

☐ Other (specify): ____________________________________________________________

**Release records from the following dates:** ☐ All dates of treatment or _____ through _____

**For the following purpose** (check all that apply)**:**

☐ Permission to discuss care ☐ For another provider ☐ Personal Use ☐ Letters/Forms

☐ Other__________________________________________________________________________

**This authorization will expire on:** ____________ If no date is included, the authorization will expire in 90 days

-I understand that I may revoke this consent at any time, that my revocation must be submitted in writing to the Counseling Center, and that the revocation shall be effective except for information already released under this authorization.

-I understand this information may be communicated in person, by telephone, email, and/or other written means. Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by privacy law, if applicable.

**I have read and understand this information. I am the client or am authorized to act on behalf of the client to sign this document authorizing the use or disclosure of protected health information under the above stated terms.**

If patient is unable to sign, secure consent of legal representative and indicate reason:
☐ Minor ☐ Incompetent ☐ Deceased

______________________________________________
**Signature of Client** **Date**

______________________________________________
**Signature of Legal Representative and Relationship to Client** **Date**

______________________________________________
**Signature of Witness (REQUIRED)** **Date**

Revised 6/16 NH