

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **UKID#** \_\_\_\_\_

Authorization is hereby granted to the UK Counseling Center to exchange relevant clinical information with:

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| <input type="checkbox"/> <b>University Health Service</b> 830 S. Limestone Street,<br>Lexington, KY 40536-0582, (859) 323-5511<br><input type="checkbox"/> <b>Dean of Students Office (including CSI team)</b><br>513 Patterson Tower, Lexington, KY 40506-0027, (859) 257-3754<br><input type="checkbox"/> <b>Violence Intervention &amp; Prevention Ctr.</b> 406<br>Administration Dr., Lexington, KY 40506-0031, (859) 257-3574<br><input type="checkbox"/> <b>Office of Student Financial Aid,</b> 128 Funkhouser<br>Building, Lexington, KY 40506-0054, (859) 257-3172<br><input type="checkbox"/> <b>Residence Life,</b> 537 Patterson Office Tower, Lexington, KY<br>40506-0027, (859) 257-4784<br><input type="checkbox"/> <b>Retroactive Withdrawal Committee</b> | <input type="checkbox"/> <b>Disability Resource Center</b><br>725 Rose St, Ste 407, Lexington, KY 40536-0029, (859) 257-0082<br><input type="checkbox"/> <b>UK HealthCare Good Samaritan Hospital</b><br>310 S. Limestone, Lexington, KY 40508-8633, (859) 226-7000<br><input type="checkbox"/> <b>Jesse G. Harris, Jr. Psych Services Center</b><br>644 Maxwellton Court, Lexington, KY 40508-3225, (859) 257-6853<br><input type="checkbox"/> <b>James W. Stuckert Career Center</b><br>408 Rose Street, Lexington, KY 40506-0494, (859) 257-2746<br><input type="checkbox"/> <b>UK Athletics</b> Joe Craft Center, 338 Lexington Ave., Lexington,<br>KY 40506-0604, (859) 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
- 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.**

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Legal Representative and Relationship to Client Date

\_\_\_\_\_  
Signature of Witness (REQUIRED) Date

If client is unable to sign, secure consent of legal representative and indicate reason:

Minor  Incompetent  Deceased