



**AUTHORIZATION FOR RELEASE OF INFORMATION
For Counseling & Psychological Services and SHARE
University Health Services**

Frist Health Center, Princeton, NJ 08544
Counseling Psychological Services - Ph. 609-258-3141, Fax 609-258-7636
Sexual Harassment/Assault Advising, Resources & Education – Ph. 609-258-3310

STATUS – please check one
 ___ PU Undergraduate Class ___
 ___ PU Grad Student- Last Year Attended ___
 ___ Dependent
 ___ Faculty/Staff

*I hereby authorize Princeton University Health Services to use or disclose my health information as described below. I understand that this authorization is voluntary and I may refuse to sign it. **I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by privacy policies or regulations.** (See exceptions below)*

Client Name _____ Date of Birth _____ Email _____ Ph _____

I hereby authorize disclosure of my health information as follows: (Check all that apply)

Counseling and Psychological Services/health information, including alcohol and/or drug information if applicable. The following information pertaining to my care may be exchanged:

- Diagnosis; Course of treatment; Treatment recommendations;
 Other: _____

Sexual Harassment/Assault Advising, Resources & Educations (SHARE)

- Confirmation that client is working with SHARE office Specific SHARE related issue being addressed
 Other: _____

(Disclosure of HIV-related information is controlled by New Jersey law, N.J.S.A. 26:5C. Disclosure of certain alcohol and drug abuse information is controlled by federal law, 42 C.F.R. Part 2. RECIPIENTS: please note that re-disclosure of either type of information is prohibited without additional written authorization unless otherwise permitted by state or federal law.)

The purpose of this release of information is for:

- Evaluation
 Treatment planning
 Continuity of care
 Insurance claims information
 Advocacy
 Background check
 Personal Use
 Other _____

I hereby authorize _____ to: release to obtain from exchange with
 [UHS or other entity]

Name _____

Address _____

Phone & fax _____

Expiration (check one)

- 12 months from the date on which I, or my legal representative, signs this authorization; or
 Other (please specify): _____

Right to Revoke: *I understand that I may revoke this authorization at any time by providing written notice to University Health Services. I understand that my revocation will not affect actions taken before receipt of the revocation by University Health Services.*

I understand that the University will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this authorization.

Signature of Client or Legal Representative _____ Date _____

Printed Name of Client or Legal Representative _____ Relationship to Client _____

Witness _____ Date _____



**AUTHORIZATION FOR RELEASE OF INFORMATION
For Counseling & Psychological Services and SHARE
University Health Services**

McCosh Health Center, Princeton, NJ 08544
Counseling Psychological Services - Ph. 609-258-3285, Fax 609-258-7636
Sexual Harassment/Assault Advising, Resources & Education – Ph 609-258-3310

STATUS – please check one

____ PU Undergraduate Class ____
____ PU Grad Student- Last Year Attended ____
____ Dependent
____ Faculty/Staff

I understand that the University will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this revocation.

Client Name _____ Date of Birth _____ Email _____ Ph _____

I hereby revoke my authorization to release my records from _____ to _____.

Effective Date _____

Signature of Client or Legal Representative _____

Date _____

Printed Name of Client or Legal Representative _____

Relationship to Client _____

Witness _____

Date _____