University Health Services

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 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 _____

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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_____