Authorization for the Release of Information and Protected Health Records

Northland College Counseling Services

1411 Ellis Avenue Ashland, Wisconsin 54806
Phone: (715) 682-1369 Fax: (715) 682-1879

Name: _____

Home Address: _____

School Address _____

DOB: _____ SSN: _____

Phone: _____

I authorize

☐ Receive from ☐ Release to

Name: _____

Attn: _____

Address _____

Phone: _____ Fax: _____

☐ Verbally ☐ In writing (including fax and email)

The following protected health information:

_____

_____

_____

Purpose of this authorization _____

This authorization will expire _____

To the extent that my records contain information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information. ☐

I understand that I have a right to revoke this authorization at any time by providing Northland College Counseling Services with written notice of revocation. The revocation will be effective upon receipt by the counseling department, except with respect to uses or disclosures made prior to receipt and in reliance upon this Authorization. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from Northland College Counseling and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent Northland College Counseling, and/or the other named person, facility or agency, from providing appropriate and necessary care.

Please note that once the requested information is disclosed pursuant to this Authorization, Northland College Counseling Services will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act.

_____ _____

Signature Date