Student Wellness Center
CCSU
Central Connecticut State University

Authorization to Obtain and/or Disclose Counseling and/or Health Information

CLIENT'S NAME:		*DATE OF BIRTH:*
ADDRESS:		*PHONE:*
CITY: *STATE:* *ZIP CODE:*		
CURRENTLY CCSU STUDENT? ☐*Yes* ☐*No*	*LAST DATE OF ATTENDANCE:*	*STUDENT ID:*

I hereby authorize Central Connecticut State University's Student Wellness Center and its staff to ☐**disclose** ☐**obtain** information about me and my mental health and/or medical records to/from the person/organization listed below:

PERSON'S OR ORGANIZATION'S NAME:		*PHONE:*
ADDRESS:		*FAX:*
CITY: *STATE:* *ZIP CODE:*		

Information to be obtained should be sent to: Student Wellness Center, Central Connecticut State University, 1615 Stanley St., New Britain, CT 06052 Attn: _____ or faxed to: _____.

The information that is obtained and/or disclosed may include my mental health, substance use, HIV-related, and/or medical service or treatment information. This information may be disclosed in a verbal, written or electronic format.

Service area(s) **to be disclosed** and/or **to be obtained** (please check only one of the following):

☐ Counseling Services Only ☐ Health Services only ☐ Both Counseling and Health Services

Please specify below the information from the service area(s) checked above to be disclosed and/or obtained (please check one or more of the following):

☐ Intake and Discharge Summaries ☐ Treatment or Appointment Summaries
☐ Psychiatric Evaluations ☐ Session/Appointment Notes
☐ Social Histories ☐ Diagnoses, Prognoses, Recommendations
☐ Lab Results ☐ Other (please specify): _____

Please ***DO NOT*** release the following information:_____

I am requesting that this information be disclosed/obtained for the purpose of (please check one or more of the following or write "at the request of the individual" under "Other" if you do not desire to state a specific reason):

☐ Continuation of Care/Treatment ☐ Legal Reasons
☐ Coordination of Care/Treatment ☐ Disability Determination or Redetermination
☐ Psychiatric Evaluation ☐ Educational/Academic Reasons
☐ Insurance Eligibility/Benefits ☐ Another Clinical or Medical Opinion
☐ Other: _____

I understand this authorization may be revoked in writing to the Student Wellness Center at any time, except to the extent that action has already been taken regarding this authorization. This authorization shall automatically expire one (1) year from the date of signature or sooner if specified. **DATE OF EXPIRATION: _____.**

I understand that I may inspect and copy the information disclosed under this authorization and that I may receive a copy of this signed authorized form. There may be a fee associated with copying, but not to exceed the amount authorized under Connecticut State Law.

I hereby release the State of Connecticut, Central Connecticut State University, and its employees and agents from any liability arising from this disclosure, including the negligent disclosure, of the information that Central Connecticut State University is herein authorized to disclose.

I understand that Central Connecticut State University's Student Wellness Center may not condition treatment on the execution of this authorization except where the disclosure of communications and records is necessary for treatment. In cases of research-related treatment protocols or studies being conducted by outside third parties through Central Connecticut State University's Student Wellness Center , specific authorization for the disclosure of records in connection with research-related treatment protocols/studies must be signed as a condition of participation.

I understand that HIV/AIDS-related information disclosed may include whether the client has received counseling, been tested for, or has HIV/HIV-related illness or AIDS or could identify the client as having one or more of these conditions. This disclosure may also include information about the client's spouse, sexual partner, or person with whom the client shared needles or syringes.

***Notices to Recipient**s:*

As the recipient of this information, this information may only be used for the stated purpose. It may ONLY be disclosed to another party if there is written authorization from the client or his/her legal representative as required or authorized by state and/or federal law.

***If this disclosure includes privileged mental health or medical information the following shall apply**: The confidentiality of this information is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or other authorization as permitted in said statute.*

If this disclosure contains information relating to alcohol or drug abuse education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) prohibit making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal regulations restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

If this disclosure includes HIV/AIDS related information protected under Connecticut law and the following shall apply: This information has been disclosed from records whose confidentiality is protected by state law. State law prohibits making any further disclosure without the specific written consent of the person of the person to whom it pertains or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

If the client is a minor (age 17 or younger): Any disclosure of drug and alcohol use records, mental health records for treatment provided with the minor's consent only under CT Gen Stat § 19a-14c and/or HIV/AIDS-related information requires the signature of the minor client below. Records or information will not be released without this signature.

*By signing below, I acknowledge that I have read and understand this authorization, as well as that I am the client listed or legal guardian of the client. I also acknowledge that **Central Connecticut State University's Student Wellness Center is not a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) federal privacy regulations and is, consequently, not subject to those regulations, but is subject to the confidentiality provisions in the federal Family Educational Rights and Privacy Act (FERPA) .***

_____

Printed Name of Client

_____ _____

Signature of Client or Legal Guardian, Conservator, Power of Attorney *Date*

_____ _____

*Printed name of Legal Guardian Conservator, Power of Attorney** *Relationship to client*

** Attach documentation of this individual's legal authority to act on behalf of the client.*

For Office Use Only

Sign & Date:	Date records needed by:
Check identification:	Copy of Authorization was provided to provider: