BUFFALO STATE
The State University of New York

Counseling Center
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Authorization for Release of Protected Health Information

Patient Name_____ **DOB:** _____ **Banner ID:** _____

_____ (*Initial*) I understand that by signing this form I am requesting that protected health information regarding my care and treatment at **The Counseling Center at Buffalo State** be released to another person/agency.

_____ (*Initial*) This authorization may include sharing of **protected health information as it relates to mental health treatment**, **drug & alcohol treatment, or HIV/AIDS status**. The disclosure will go to the person/agency identified below.

_____ (*Initial*) I understand that my information may be released to people/agencies who have different privacy laws than mental health providers. Once released, The Counseling Center cannot guarantee the information will be protected by the other party. Nonetheless, recipients of this information are prohibited, by law, from re-disclosing health information as it relates to **mental health treatment**, **drug & alcohol treatment, or HIV/AIDS status** to other agencies. Any requests by third-party agencies should be re-directed to the original source.

_____ (*Initial*) I understand that signing this form is completely voluntary. Unless otherwise specified, the document will be good for one year after it is signed. I understand that I have the right to withdraw my consent at any time (to the extent that information has not already been released). In order to withdraw your consent, you must communicate this to The Counseling Center at Buffalo State, verbally or in writing.

I _____ hereby authorize The Counseling Center at Buffalo State to:
(*name*)

_____ **Release information to:**
_____ **Obtain information from:**

Person/Agency _____
Address _____
Phone/Fax Number (P) _____ (F) _____

I would like The Counseling Center to release and/or obtain the following information about me:

_____ Involvement in Treatment
_____ Dates of Treatment & Attendance
_____ Treatment Summary
_____ Full History/ Initial Assessment
_____ Diagnoses
_____ Treatment Recommendations
_____ Psychiatric Evaluation
_____ Medications & Medication Compliance
_____ (*please initial*) HIV-related information_____ (*please initial*) Substance use information
_____ Other (*specify*) _____

For The Purpose Of:
_____ Treatment/Support Coordination ____Academic Advocacy
_____ Other (specify) _____

_____
Signature of Patient Date

_____
Staff Member's Name (Printed) Date