BUFFALO STATE
The State University of New York

Counseling Center
Weigel 219
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Buffalo, NY 14222-1095
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Authorization for Release of Protected Health Information – Say Yes Program

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:

☐ **Release information to:** ☐ **Obtain information from:**

Person/Agency	Best Self Behavioral Health, Linwood Community Services
Address	625 Delaware Ave, Buffalo, NY 14202
Phone/Fax Number	Phone: (716) 882-315 Fax: (716) 886-4002

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*) Insurance information (if applicable) _____

For the Purpose Of: ☐ Treatment/Support Coordination ☐ Other (specify)

Typing my full legal name (after "/s/") and date below constitutes my signature:

Signature of Patient: /s/ _____ Date: _____

Once signed, this form can be returned via email to counselingcenter@buffalostate.edu or via mail to the address above. Confidentiality of email cannot be guaranteed, as e-mail is not a 100% secure medium.