The University of Texas at Austin
Counseling and Mental Health Center
Division of Student Affairs

Authorization for Release of Protected Health Information (PHI)

I authorize the following protected mental health information to be released from the medical record of:

LAST NAME (PLEASE PRINT) _____ FIRST NAME (PLEASE PRINT) _____ KNOWN BY _____

EMAIL ADDRESS _____ UTEID _____ DATE OF BIRTH _____ TODAY'S DATE _____

☐ **Verbal disclosure to a non-provider (e.g., family, friend, SES, faculty, staff):** _____ NAME/RELATIONSHIP _____ PHONE NUMBER

To be released: ☐ Conversations as needed to facilitate continuity of care

☐ Other _____

☐ **Records release to Medical or Mental Health Provider:**

Release PHI ☐ **From** ☐ **To**

Counseling and Mental Health Center
100 A West Dean Keeton, A3500
Austin, TX 78712
Phone 512-471-3515
Fax 512-232-7314

Release PHI ☐ **To** ☐ **From**

NAME/ORGANIZATION/PROVIDER ROLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

I understand that to the extent that any recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

TO BE RELEASED	DATE OF SERVICE / PROVIDER	TO BE RELEASED
☐ Counseling records	_____	☐ Conversations as needed to facilitate continuity of care
☐ Psychiatric records	_____	
☐ Laboratory results	_____	☐ Date of appointments
☐ Treatment summary	_____	☐ Other, as specified below
☐ Other: _____		

➡ NOTE: If specific dates to be released or a specific provider are not indicated, all records in the category marked will be released.

I understand that this authorization is valid for as long as I am a UT Austin student unless I notify CMHC otherwise. I may revoke this authorization in writing at any time except to the extent that CMHC has already relied on this authorization. I may revoke it by completing a CMHC Request to Amend Record Form and stating my intention to revoke this authorization. This form must be submitted to CMHC Records at the address/fax number above. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. If I do not want some of this information released, I must review this request with CMHC Administrative staff.

I understand my treatment will not be conditioned by my completion of this form. I will be billed per the posted fee schedule. The information will be provided to me within 15 days of my request.

➡ NOTE: If mailing or faxing this form, please include a copy of your photo ID.

SIGNATURE OF CLIENT/PATIENT (OR IF LEGAL REPRESENTATIVE-STATE AUTHORITY TO ACT) _____ DATE _____

I have verified the client's/patient's identification and notified them of the fee, if applicable.

CMHC STAFF/TRAINEE SIGNATURE _____ DATE _____

CMHC STAFF ONLY

Date Released: _____ Released by: _____

Notes: _____