UNIVERSITY OF RICHMOND COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Instructions: The patient is required to complete this form in its entirety in order to be processed.

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

LAST NAME (PLEASE PRINT) _____ FIRST NAMES (PLEASE PRINT) _____ DATE OF BIRTH _____

PHONE NUMBER _____ UR ID _____ TODAY'S DATE _____

PURPOSE FOR DISCLOSURE

__Coordination of Care __Continuity of Care __Other (must specify): _____

RECORDS TO BE RELEASED

__Visit Verification __Treatment Summary & Diagnosis __Psychiatric Notes

__Other (Must Specify):_____

RELEASE RECORDS (SELECT): __FROM __TO

University of Richmond CAPS

Well-Being Center, 363 College Road

University of Richmond, VA 23173

Phone: 804-289-8119 Fax: 804-287-1227

RELEASE RECORDS (SELECT): ☐ FROM ☐ TO

_____

Name/Organization

_____

Address City, State, Zip Code

_____

FAX Number Phone Number

RELEASE RECORDS BY: ☐ Fax ☐ Pick Up at CAPS ☐ Verbal ☐ Mail

Approximate dates of service requested: _____

- I understand that I may revoke this Authorization in writing at any time and will be effective when delivered to CAPS, but will not apply to information that has already been released in response to this Authorization.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- As the person signing this authorization, I understand that I am giving my permission to use or disclose my confidential health records as indicated above. **The records may contain information from other providers, information related to drug/alcohol abuse/treatment and /or psychiatric mental health, unless specified here:_____.**
- I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.
- **This authorization will be valid for: (check one) ☐ This request only. ☐ One (1) year from date of signature.**

By signing, I hereby acknowledge that I have read this authorization and understand the nature of the release. I understand I am giving permission for the disclosure of protected health care information.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN, IF UNDER THE AGE OF 18 DATE

_____

RELATIONSHIP TO PATIENT

NOTICE TO RECIPIENT OF RECORDS: The attached medical information is protected by federal privacy laws. You may not make further disclosures of the information without consent of the patient. In addition, you may use the information only for the purpose(s) for which the disclosure was made.

For Office Use Only:

Date Released: _____ Patient Identification Verified ____ Initials of Processor_____