University Health Center
Counseling & Psychiatric Services (CAPS)
The University of Georgia
55 Carlton Street
Athens, GA 30602-1503
(706) 542-2273 (706) 542-8661 (Fax)

Name: _____

UGA ID (81#)_____

DOB: _____

Phone: _____

Request for Admin Action *(select one)*:
☐ REQUEST OUTSIDE RECORDS
☐ SEND CAPS RECORDS

☐ Consultation/Communication

☐ Letter or Form

RECORDS RELEASE AUTHORIZATION

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and you may make changes at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

1. **I AUTHORIZE CAPS at THE UNIVERSITY HEALTH CENTER to ☐ RELEASE ☐ RECEIVE** psychological/psychiatric mental health information to/from the SECOND PARTY as directed below:

2. **SECOND PARTY:**

Name:_____

Address:_____

City: _____ **State:** _____ **Zip:** _____

Fax Number: _____ **Phone:** _____

3. **DESCRIPTION OF MENTAL HEALTH INFORMATION TO BE DISCLOSED:**

☐ Alcohol & Substance abuse ☐ Discharge/services summary ☐ Confidential HIV information
☐ Initial evaluation ☐ Progress notes ☐ Treatment team/consultation note(s)
☐ Medication List ☐ Lab Results ☐ Diagnosis
☐ Verification of attendance/participation in CAPS
Other _____

4. **PURPOSE OF DISCLOSURE:**

☐ Consultation (Verbal) ☐ Continuation of Care ☐ Evaluation of academic concern/course withdrawal request
☐ Personal use
☐ Insurance ☐ Parent/Partner consult
Other _____

5. **Note any exclusions or limitations here:** _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. However, UHC may deem the provision of health care for the purpose of disclosing to a third party protected health information specifically created for that third party, or for participating in research related treatment, upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to Counseling and Psychiatric Services to disclose my records, and that I may revoke this Authorization, except if this Authorization was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to the University Health Center to the attention of the Manager, CAPS. The revocation shall be effective except to the extent that UHC has already used or disclosed information in reliance on the Authorization. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information **may** no longer be protected under the terms of this agreement. **Please refer to the *Notice of Health Information Privacy Practices* for more detailed information. This consent form will expire one year following the date signed unless revoked by you in writing or upon the happening of an event/condition as listed on the following date:** _____

***Signature:** _____ **Date:** _____

Legal Guardian/Person Representative: _____Date:_____

-Note below if Authorization is given on this patient's behalf due to being a minor or unable to sign for the following reasons:

***Witnessed by:** _____ **Date:** _____ **Client Copy Received:** ☐ **Yes** ☐ **Client Declined**

Revised 8/15, 1/17, 02/19, 12/19
Reviewed: 7/14, 6/16, 6/18

--A fax or photocopy serves the same as the original.