



Information Release Form

Name: Last First MI Date of Birth

Address: Phone:

Network ID:

University Status: [ ] Enrolled Student [ ] Alumni/Former Student [ ] Employee

I hereby give permission to the University Health & Counseling Services to:

- [ ] Release information to:
[ ] Obtain information from:

Check appropriate box and specify below; use multiple forms for each request/recipient:

- [ ] University / Institute Office or Staff [ ] Family / Relative / Partner [ ] Healthcare Provider or Facility [ ] Self / Other

Name
Address City State Zip
Phone Fax email

INFORMATION REQUESTED:

- [ ] Treatment Summary [ ] Immunization
[ ] Treatment Dates / Verification of Appointments [ ] Lab/X-Ray Reports
[ ] Psychological Assessment Summary [ ] Recommendations
[ ] Psychiatry / Medication Summary [ ] Permission to observe/participate in session

[ ] Other

I understand and authorize University Health & Counseling Services to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse.

FOR THE PURPOSE OF:

This authorization is valid from: \_\_\_\_\_, 20\_\_, until \_\_\_\_\_, 20\_\_, or one (1) year from the date of the authorized signature below, whichever occurs first. I (or my legal representative) can revoke this authorization at any time through written notice. Any revocation will not apply to information that has already been released in response to this authorization.

Authorizing Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are a student enrolled at Case Western Reserve University, your records maintained in the University Health & Counseling Services are protected under FERPA. For more information, see the University Registrar's website. UH&CS upholds applicable federal and state laws and professional ethical guidelines.