Authorization to Release Information

Calvin University
Dean of Students Office (SC364), 3201 Burton St SE, Grand Rapids, MI 49546
616-526-6546 (phone) / 616-469-2979 (fax - c/o Center for Counseling and Wellness)

Student Name: _____ Date of Birth: _____
Phone Number: _____ Calvin ID#: _____
Address: _____

I authorize the treatment provider(s) or organization(s) named below to exchange information with Calvin University personnel pertaining to my evaluation and/or treatment, for the purpose of assessing my health needs:

Name of provider and/or organization: _____
Contact information: _____

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Contact information: _____

Name of provider and/or organization: _____
Contact information: _____

I authorize the release of any and all of the following medical and/or mental health information, as specified, which may be contained in my records: *(check all that apply)*

___ Initial Evaluation
___ Progress Notes
___ Letter or other written communication which summarizes assessment and treatment
___ Verbal summary of assessment and treatment
___ Information regarding drug or alcohol use
___ Information regarding testing, diagnosing, or treatment or HIV/AIDS or other sexually transmitted diseases.
___ Other (please specify:_____)

I understand that the purpose of the disclosure is: *(check all that apply)*

___ To assure for continuity and coordination of care
___ To inform university personnel of my health needs and treatment recommendations
___ Other (please specify: _____)

By my signature below, I understand that I am giving my permission to the above-named people and/or organizations to disclose confidential medical and/or mental health information.

I understand that I have the right to revoke this authorization at any time. If I choose to revoke this authorization, I understand that I will need to file a written request. I understand that I have the right to refuse to sign this authorization and that refusing will not affect my ability to receive services. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) protects the privacy of health information. Persons or organizations receiving this health information may not be bound to the provisions of this law. However, re-disclosure of this information is prohibited by the Michigan Mental Health Code (sections 748, 749, and 750 of the Public Act 258 of 1974).

This authorization shall expire one year from the date indicated after my signature or upon the following date, event, or condition: _____

Signature of Student:_____ Date:_____

Signature of Witness:_____