COUNSELING & PSYCHOLOGICAL SERVICES
1971 UNIVERSITY BLVD, LIBERTY UNIVERSITY
LYNCHBURG, VA 24515
PHONE (434) 582-2651
FAX (540) 582-3904

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby request that Counseling & Psychological Services at Liberty
Name (Print)
University engage in the following as it relates to my records.

In accordance with this request, I hereby release and forever discharge and agree to hold harmless and indemnify the Commonwealth of Virginia, Liberty University, the Counseling & Psychological Services administration and staff, and all other officers, agents and employees of the University from any and all claims, demands, damages, actions or suits of law or in equity of whatever kind which might arise in accordance with my request.

Purpose of Disclosure:

____Continued care
____Employment
____Legal
____Personal knowledge
____Insurance
____Other_____

Additional information about purpose of disclosure:

_____

Check all desired:

_____Please have the following information **from** an outside person/provider/agency conveyed to Liberty University's Counseling & Psychological Services.
_____Please have Liberty University's Counseling & Psychological Services convey the following information **to** an outside person/provider/agency (allow 2 weeks to process).

COUNSELING RECORDS

_____Treatment summary
_____Diagnosis
_____Treatment recommendations
_____Dates of treatment
_____Testing results
_____Other_____
_____Exclusions (items not to be disclosed) _____

How would you like this information communicated?

____Verbal discussion
____Written information
____Other_____

_____

Outside person/provider/title

_____

Name of agency/affiliation/relationship

_____

Mailing address: street, city, and zip code

_____

Phone and fax number

I understand this authorization is voluntary and not a condition of treatment. This authorization is automatically void after 1 year, and may be terminated by me at any time with a written notice, effective as of the date of signature. Information sent and/or received through this authorization may not be re-released to another individual or agency.

I may revoke authorization at any time, but my revocation is not effective until delivered in writing to Liberty University's Counseling & Psychological Services (CAPS) and is not effective as to health records already disclosed under this authorization. A copy of this authorization and notation concerning the persons or agencies to which disclosure was made will also be included with my original health records.

I understand that although CAPS is not a covered entity as it pertains to HIPAA regulations, the counseling center respects and restricts access to records for my confidentiality.

I understand CAPS cannot respond to background checks or security clearance questionnaires which require assessment and/or prediction of behaviors regarding a person's fitness to safeguard national security information. We will, however, provide dates of treatment, diagnoses, and presenting concerns at CAPS.

I understand that CAPS recommends a treatment summary for third party requests (non-health care providers). I am entitled to request my health records and if I choose to share my records with third party individuals (non-health care providers), I understand there may be risks to how clinical information is interpreted and used to make decisions on my behalf.

I understand that I may ask to see copies of my health record as well as information about any disclosures that were made.

_____ ***Please initial to indicate that the release of your records may include information related to substance use which is protected by Federal Regulations (42 CRF Part 2) and requires specific written authorization for such disclosure. Federal Regulations restrict use of any disclosure from being used in criminal investigations.***

_____ Name of student (print)

_____ Phone number of student

_____ Signature of student

_____ Date

_____ Student identification number

_____/_____/_____ Date of birth

_____ Witness Signature / CAPS Staff Signature

_____ Date

office use only scan only: ☐ sent records: ☐ requested records: ☐

Information released:_____

Signature: _____ Date:_____