SAINT LOUIS UNIVERSITY
EST. 1818

3700 Lindell Boulevard
Morrissey Hall, Room 1200
St. Louis, MO 63108
Phone: 314-977-2278
Fax: 314-977-1006

THE PSYCHOLOGICAL SERVICES CENTER
AUTHORIZATION FOR DISCLOSURE OF CLIENT MEDICAL/HEALTH INFORMATION

I,_____, authorize and request the Psychological Services
(Name of Client, Parent, Guardian/Legal Representative)
Center, Saint Louis University, 1200 Morrissey Hall, Room 1200, St. Louis, Missouri 63108, to release and/or obtain information for:

Client's Name	Date of Birth	Social Security Number
_____	_____	_____

To/From _____
(Name of Person or Organization)
_____
(Telephone)
_____
(Address, City, State and Zip Code)

Information to be released:

Date(s) of service: _____

____ Medical Records	____ History and Physical
____ Psychological Evaluation(s)	____ Discharge Summary
____ History and Physical	____ Radiology Reports
____ All School Records	____ Physician Orders
____ Teach Rating Scales	____ Entire Record
____ Interview with Teacher/Staff	____ Operative Reports
____ Laboratory Reports	____ Entire Record

____ Specific Information: _____
_____
_____

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____ Interview with Teacher/Staff	____ Operative Reports
____ Laboratory Reports	____ Entire Record

____ Specific Information: _____
_____
_____

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to the following:

☐ Sexually Transmitted Diseases
☐ Human Immunodeficiency Virus (HIV)
☐ Alcohol or Drug Abuse
☐ Acquired Immunodeficiency Syndrome (AIDS)
☐ Other communicable diseases

2. This authorization includes both information presently compiled and information to be compiled during the course of treatment or services at the above-named facility or agency paying for services during the specified time frame.

3. This authorization becomes effective on the date it is signed. This authorization automatically expires on the following date, event, or special condition _____

4. If I fail to specify an expiration date, this authorization will expire in one year.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the Clinic Director at the Psychological Services Center. I further understand that actions already taken based on this authorization, prior to revocation, will NOT be affected.

6. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**

7. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. **In addition to elsewhere in this document, please sign below if you are authorizing the release of alcohol and drug abuse information:**

_____
(Signature of Client or Legal Guardian)

NOTE: Prohibition of Redisclosure: Information that has been disclosed from records whose confidentiality is protected by Federal law (42 CFR 2) that prohibits further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment from Psychological Services Center. I understand that I may request to inspect or request a copy of information to be used or disclosed. I understand that any disclosure of information carries the potential for redisclosure by the recipient and may no longer be protected by applicable confidentiality laws. If I have questions about disclosure of my medical/health information, I can contact the Clinic Director of the Psychological Services Center.

My signature below acknowledges that I have read, understand, and authorize the disclosure of my PHI. I have read and understand this consent and I have signed it voluntarily and of my own free will.

X _____
Signature of Client or Legal Guardian Date

X _____
Witness's Signature Date

Relationship to Patient_____

NOTICE OF REVOCATION (only sign below if you are REVOKING an authorization)

I, _____, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any disclosures by Psychological Services Center based on this authorization, prior to receipt of this revocation, will not be affected.

X _____ X _____

Signature of Client or Legal Guardian Date Witness's Signature Date

If you choose to revoke your authorization, please provide a copy of the completed revocation to the Clinic Director of this agency:

a) By Mail: Attn: Dr. Laura Burch
Psychological Services Center
Saint Louis University
3700 Morrissey Hall
Room 1200
St. Louis, MO 63108

b) By telephone: 314-977-2274
c) By fax: 314-977-1006