

CONSENT TO RELEASE INFORMATION_____
Patient Name (Please Print)_____/_____/_____
Date of Birth_____
PSU ID# or SSN

I authorize the Health and Wellness Center, 3000 Ivyside Park, Altoona, PA 16601, to Disclose/Receive (circle one) information contained in my record to/from (circle one):

Name _____ Organization/Agency: _____ Fax: _____

Address _____ City _____ State _____ Zip _____

Purpose for disclosure: Continuation of Care Payment of Claim Retroactive Withdrawal
 Other _____**The information to be released is confined to the following:**

Counseling/Psych. Services <input type="checkbox"/> Attendance <input type="checkbox"/> Diagnosis/Assessment <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Psychosocial History <input type="checkbox"/> Treatment Summary <input type="checkbox"/> Other: _____	Health Services/Health Education <input type="checkbox"/> Health Hx/Immunization Records <input type="checkbox"/> Physical Exam <input type="checkbox"/> GYN. Exam <input type="checkbox"/> Treatment Notes <input type="checkbox"/> Lab Reports <input type="checkbox"/> X-ray Reports <input type="checkbox"/> Other: _____ <input type="checkbox"/> AWARE/IMPACT Program Attendance and Compliance	Student Disability Resources <input type="checkbox"/> Documentation of my Disability <input type="checkbox"/> Accommodation Forms <input type="checkbox"/> Other: _____
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I understand that my record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health, HIV and/or AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information not be disclosed by initialing below: Alcohol/Drug Use Mental Health. HIV and/or AIDS. Sexual Assault

Specific information to be disclosed: copies verbal consultation.

- I understand this release is valid _____ days or for one year from the date it was signed. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Health and Wellness Center. The staff of the Health and Wellness Center can not be held legally liable for the interpretation or use by person/persons to whom they are released.

I have read and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose(s) stated above.

The treatment dates covered by this authorization are from _____ to _____.

Patient Signature_____
Date_____
Witness Signature_____
Date**DISCLOSURE**

This information has been disclosed to you from records protected by State and Federal Laws. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. Information related to HIV/AIDS, alcohol and other drugs, and mental health and abuse issues are protected by law and a general authorization for the release of medical or other information is not sufficient for this purpose.

A copy of the Authorization shall be deemed valid as original. This Authorization must be signed and dated.

Approved by: _____ Date: _____ Released by: _____ Date: _____

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