Cox Health and Counseling Center
104 W. Scott Lane, Gambier OH 43022
Health: 740-427-5525 fax: 740-427-5527
Counseling: 740-427-5643 fax:740-427-5446

CONSENT FOR RELEASE OF INFORMATION

Student ID or SS# _____ Student Name (Please Print) _____ Date of Birth _____

I authorize the Cox Health and Counseling Center to **DISCLOSE/RECEIVE** (circle one) information contained in my record **TO/FROM** (circle one) the following:

Name: _____ Organization/Agency: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose for Disclosure: □ Continuity of Care between Health Care Providers □ Disability Determination □ Judicial Proceeding
□ Insurance Claim □ Court Related □ Academic Support and Accommodation □ Employment □ Study Abroad □ Title IX
□ Parent/Guardian □ Coach □ Residential Life □ Other_____

Please note: ***Only the boxes that are checked below will be shared.***

Counseling Services	Health Services	SASS Resources (Student Accessibility and Support Services)
□ Attendance □ Psychosocial History □ Alcohol or Drug Abuse Counseling □ Psychiatry/Psychotherapy notes* □ Consults from other providers □ Email correspondence □ Other _____ □ Restrictions: _____ **Psychiatry/Psychotherapy notes include: Diagnosis/Assessment, Treatment plans/Summaries*	□ Immunizations □ Medical Health Record* □ Diagnostic/Lab reports** □ Consults from other providers □ Emergency Room Records □ Email Correspondence □ Other _____ □ Restrictions: _____ **Medical Health Record includes: visits to Health Center, All contents of medical record* ***Diagnostic/Lab reports include: Diagnostic Testing, STD/HIV testing*	□ Documentation of Disability □ Accommodation Forms □ ADD testing □ Other _____

Specific information to be disclosed: □ Copies □ Verbal Consultation

- I understand this release is valid _____ days or ONE YEAR (if left blank) from the date it is signed. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient. I understand authorizing the use of disclosure of this 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 by released in reliance of this form. To revoke, I must do so in writing and present it to the Health and Counseling Center. I understand that I have a right to a copy of this authorization. The staff of the Health and Counseling center cannot be 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 _____

Signature: _____ Date: _____

Parent/Guardian (if under age 18):_____ Date: _____

NOTICE TO PARTY RECEIVING INFORMATION: This information has been disclosed to you from records, whose confidentiality is protected by Federal law, which prohibits you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or otherwise permitted, by 42 C.F.R. part 2. A general authorization for the release of medical information is NOT sufficient for that purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.