AUTHORIZATION TO OBTAIN, USE AND DISCLOSE INFORMATION

Client Name:____

Client Date of Birth:___________________________________

Client Social Security Number:____________________

The Client (or parent or legal guardian if the Client is a minor) hereby authorizes

☐ Endicott College Counseling Center

☐ Endicott College Health Center

and its providers, agents and designees to **obtain** and use information from:

____

(Name of individual, agency, other)

____ _________________

(Address) (Phone Number)

And/or to **release** and disclose information to:

____

(Name of individual, agency, other)

____ _________________

(Address) (Phone Number)

If the specific information to be released is anything other than unlimited, please check the boxes below to indicate the specific information to be released:

☐ Attendance only
☐ Verbal progress updates
☐ Written treatment summary
☐ Intake Summary
☐ Progress Notes
☐ Discharge Summary
☐ Other____

The purpose of this release of information is:

_____ Evaluation _____ Assistance in treatment planning _____ Coordination of treatment
_____ Other (specify) _______________________________________

I understand that this authorization is subject to revocation at any time with written notice by Client (guardian/parent if Client is a minor) sent to the provider who holds the Client's treatment records. The authorization will last no longer than three months after treatment ends.

____ _________________________

Signature of Client Date

____ _________________________

Signature of Parent/Guardian of Client if Client is a minor Date

____ _________________________

Witness Signature Date

NOTIFICATION REGARDING PROTECTED INFORMATION

Your signature on the front side of this authorization does not automatically pertain to the categories listed below. The information in the protected categories listed below will not be released to the **Recipients** from your record without your signature on this page or a legally valid subpoena or court order. Therefore, by initialing the check box next to each category below, the undersigned authorizes Endicott College Counseling Center to release information to the **Recipients** pertaining to each category:

- ☐ Alcohol Abuse
- ☐ HIV Testing
- ☐ Drug Abuse
- ☐ Sexual Assault
- ☐ Hepatitis B Testing/Treatment
- ☐ Sexually Transmitted Disease
- ☐ Office notes
- ☐ Lab tests and results
- ☐ Aids-ARC
- ☐ Abortion
- ☐ Domestic Violence
- ☐ Rape Counseling
- ☐ Hepatitis C Testing/Treatment
- ☐ Immunizations
- ☐ All of the above

The authorization to release information to the **Recipients** pertaining to these protected categories will last no longer than three months after treatment termination, unless you state otherwise in writing.

I also understand that my signature on the separate form entitled "Notification Regarding Confidentiality" may allow the disclosures discussed in that form, notwithstanding the information contained in this Notification Regarding Protected Information.

______________________________________ ____________________

Signature of Client Date

______________________________________ ____________________

Signature of Parent/Guardian of Client if Client is a minor Date

______________________________________ ____________________

Witness Signature Date