Henderson
Student Counseling Services

Administrative Office: 3301 College Ave., SAB 3rd Floor,
Davie, FL 33314
Phone: (954) 424-6916 Fax: (954) 424-6915

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

I _____ **DOB:** _____ **SS#:** _____
Name of Student (PLEASE PRINT)

hereby give my permission to Henderson Student Counseling Services or to the entity listed below to release information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under Florida law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in Florida or federal law.

This information will be released/requested upon request to the following:

To/From: _____
Name and Address of Person(s), Agencies, Organization to which information is to be released/requested.

Purpose of this release/request: To Review 3rd Party Prescription History

I authorize release/request of information covering treatment dates of: ALL TREATMENT DATES

The type of information to be disclosed/requested is as follows:

To Be Released		To Be Requested	
____	Treatment Plans	____	Treatment Plans
____	Progress Reports	____	Progress Reports
____	Health/Medical Records	X	Health/Medical Records
____	Education Reports	____	Education Reports
____	Discharge Summaries	____	Discharge Summaries
____	Psychological/Psychiatric Evaluations	____	Psychological/Psychiatric Evaluations
____	Social/Developmental History	____	Social/Developmental History
X	Verbal Communication	X	Verbal Communication
X	Other	X	Other **Prescription History**

____(initial) I agree to allow authorized personnel, from Henderson Student Counseling Services, to receive a copy of my medical record.

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Henderson Student Counseling Services.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Henderson Student Counseling Services will not base my treatment, payment or eligibility for benefits on whether or not I provide authorization for the requested use or disclosure. I understand that the recipient may be prohibited from disclosing substance abuse information. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Henderson Student Counseling Services.

____(initial) I understand that Henderson Student Counseling Services will release only the minimum amount of information necessary to fulfill a request.

Release:

_____
Student Signature **Date**

_____
Witness **Date**

Request:

_____
Student Signature **Date**

_____
Witness **Date**