Holy Family UNIVERSITY

Department of Counseling Services
Campus Center Room 202/204
9801 Frankford Ave
Philadelphia, PA 19114s
267-341-3222

AUTHORIZATION FOR RELEASE OF CLINICAL INFORMATION

I, _____, hereby request and authorize the clinical information
(Print Name)
identified below to be:

_____ released from Holy Family University Counseling Services to the indicated party
_____ released to Holy Family University Counseling Services from the indicated party
_____ exchanged between Holy Family University Counseling Services and the indicated party

INDICATED PARTY:

Name: _____
Address: _____
_____
_____
Phone: _____

INFORMATION TO BE EXCHANGED OR RELEASED:

_____ Dates/Attendance of Treatment
_____ Initial Consultation Assessment/Intake Report
_____ Treatment Summary
_____ All information related to treatment
_____ Other, please specify: _____

PURPOSE OF EXCHANGE OR RELEASE OF INFORMATION:

_____ Continuity/Coordination of Care
_____ Legal/Attorney
_____ Occupational
_____ Consultation
_____ Withdrawal from or Return to Campus
_____ Other, please specify: _____

I AUTHORIZE EXCHANGE OR RELEASE OF THE ABOVE INFORMATION FOR THE FOLLOWING DATES:

_____ All dates of contact
_____ Consultation
_____ Other, please specify: _____

This Authorization for Release will expire on _____ or one year from the last date below.

I acknowledge that I may revoke this authorization at any time by a written communication to the Counseling Services Center. Revocation will not be effective as to any information released or exchanged prior to revocation. I understand that information released or exchanged pursuant to this authorization may be subject to re-disclosure. I release the Counseling Services Center, Holy Family University, its Board of Trustees, officers and employees from any liability, injuries or damages which may arise from the release or exchange of information made pursuant to this authorization.

I confirm that this Authorization for Release has been explained to me and that I understand its contents. I further confirm that this Authorization for Release has been given voluntarily.

_____ DATE: _____
STUDENT SIGNATURE

_____ DATE: _____
WITNESS SIGNATURE

_____ DATE: _____
PARENT OR GUARDIAN IF STUDENT IS UNDER 18

NOTICE: Any information that has been released or exchanged hereunder is from confidential records. Any further disclosure without the express prior written consent of the person to whom it pertains exceeds the limits of this authorization, subject, however, to any legal and ethical requirements that require disclosure in situations as prescribed by law, such as where there is danger of imminent harm to the individual or to others and in the case of apparent abuse or neglect of a child or a vulnerable adult.