Western Carolina University | College of Education and Allied Professions

Case #_____

McKee Assessment and Psychological Services Clinic
Psychology Department
Western Carolina University

Consent for Release of Confidential Information

Client Name: _____ **DOB:** _____

By signing below, I give my permission to the McKee Assessment and Psychological Services Clinic to release and/or receive the client's confidential information to/from:

Name of Facility or Person: _____

Address: _____

_____

Phone #: _____

I authorize the release of information listed below, which requires specific consent under law. (*You **MUST INTIAL** all that apply*).

____ Mental Health

____ Substance Abuse

____ ***Comprehensive Evaluation***

____ HIV/Aids-related

I authorize the following information to be released, shared, and exchanged between the McKee Assessment and Psychological Services Clinic and the agency listed above. (*You **MUST INITIAL** all that apply*).

____ ***Psychological Assessment/Report***

____ Progress Notes

____ Academic Records

____ Medical Records

____ Other, specify _____

Case #_____

The purpose of the release of this information is for: (*You **MUST INITIAL** all that apply*)

____ ***Continuity of Care*** _____ Insurance

____ Attorney/Legal _____ School/Academic Records

____ Disability/Eligibility _____ Personal Reasons

Please ***INITIAL*** each of the following statements and sign at the bottom.

_____ *I understand that my information may not be protected from re-disclosure by the requester/recipient of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (CFR 42, part 2), and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 CFR, part 160 & 164, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.*

_____ *I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment for services.*

_____ *I understand that if I fail to specify an expiration date or condition this authorization is valid for a period of one year from the signature date. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.*

I have read the above agreement and I consent to release of information as outlined above.

_____	_____	_____
Signature of Client	Date Signed	Expiration Date
_____	_____	_____
Signature of Parent/Legal Representative	Date Signed	Expiration Date

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Complete the following ONLY if you wish to revoke the authorization:

I, _____, am revoking this Consent to Release Information,

effective ___/___/__.