FLORIDA STATE UNIVERSITY

Authorization for the Use, Disclosure, and Receipt of Protected Health Information

I _____ request and authorize my Health Provider:

Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

To release my medical information to the University Health Services or University Counseling Center (as appropriate) for the purpose of a Medical/Mental Health Withdrawal review. ***You must attach ALL Medical Documentation to this Form and send all relevant documentation to:***

FSU **Medical** Course Drop and Withdrawal Committee

☐ **C/O Tyler Shannon & Lonita Jackson**
University Health Services
960 Learning Way
Tallahassee, Florida 32306-4178
Phone: 850-644-1624 / Fax: 850-644-2737
uhs-coursedrop@fsu.edu

OR

FSU **Mental Health** Course Drop & Withdrawal Committee

☐ **C/O Tyler Shannon & Lonita Jackson**
University Counseling Center
250 Askew Student Life Building
942 Learning Way
Tallahassee, Florida 32306-4175
Phone: 850-644-1624 / Fax: 850-644-3150
uhs-coursedrop@fsu.edu

Records Authorized to be Obtained

Date Range and Specific Medical Records Requested: _____/ _____/ _____ to _____/ _____/ _____

(Note: The date range should be relevant to the Semester in question, but may need to include relevant information just prior to the semester or immediately following).

Please Check all items you will be submitting to support your case:

_____ **ANY and ALL** Medical, Psychiatric, Counseling, or Psychological records including alcohol/drug abuse, addiction records, STD/HIV information within the date range noted above.

_____ General Medical Records (including all office visit notes, diagnostic tests, consultations, counseling and HIV information/test results).

_____ Mental Health Records only (Psychologist/Mental Health Counselor or Primary Care Clinician)*****

_____ Psychiatry Clinic Records only***** _____ Specific Evaluation or Consultation Report and date: _____

_____ Other _____

****By law, Mental Health Care Professionals may substitute a summary letter in lieu of full records.***

Purpose of Disclosure:

Course Drop/Withdrawal: The Course Drop/Withdrawal Committee is made up of health care professionals who review the medical and/or mental health records; consultation with your appropriate Academic Dean or the Director of Withdrawal Services may be necessary but personal medical information is rarely shared. This authorizes the named person, agency, clinic or organization to release medical, mental health, psychiatric, social or psychological records including alcohol and drug abuse or addiction records, or STD information except as limited above.

I understand that the information in my records may include information relating to: Alcohol/Drug Abuse, STI/STDS, HIV/AIDS, Behavioral and/or Genetics.
I understand that a summary of the Mental Health records may be provided in lieu of complete Psychiatric records at the discretion of the Clinician.

I understand that once information is disclosed, the information is subject to redisclosure and may no longer be protected by federal privacy regulations.
I understand that I have a right to revoke this authorization at any time except in the case that action has already been taken in regards to the request for authorization. **I understand that** if I revoke this authorization I must do so in writing and present my written revocation to the Information Management Department of University Health Services or the University Counseling Center. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire in six (6) months from the date signed below**

Expiration Date: _____ (*If left blank, authorization will expire six (6) months*)

Name: _____ Birth date: _____/ _____/ _____ Phone: (_____)_____-_____

Address: _____

This release will be valid for _____from the date of my signature.

Signature of Student or *****Legal Representative _____ Date: _____

Relationship: _____ Date: _____

***** ***Note: Please attach a copy of the Power of Attorney***

Please Note: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (FL395.017, 455.241 and 394.459) and federal law 42 CFR, part II. **Prohibition on redisclosure of information pertaining to alcohol and drug abuse records:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or client.