University Counseling and Testing Center (UCTC)

300 Alumni Circle, Mobile, AL 36688/(Telephone) 251-460-7051/(Fax) 251-460-7492

Authorization for Release of Protected Health Information (PHI)

NAME:_____ DATE OF BIRTH_____/_____/_____

ADDRESS_____

PHONE NO. (_____)_____ J NUMBER _____

I hereby authorize the UCTC or any of its staff to use, disclose, or obtain by any acceptable means, including fax, phone, or email my Protected Health Information.

Check the one that applies: Use PHI Disclose PHI Obtain PHI

Dates of records to be released: _____

PHI to be used, disclosed, or obtained:

δ

δ Treatment Provider (*fill in information below*)

δ Student Disability Services

δ Parents/Other Family (*fill in information below*)

δ Dean of Students Office

δ OTHER _____

RECIPIENT'S NAME: _____ ADDRESS: _____

_____PHONE: _____ FAX: _____

The purpose of this use, disclosure or obtainment is:

δ At the request of the client

δ Letter of Support

δ Coordination/Continuity of Care

δ OTHER _____

_____ _____

Signature of Client or Client's Legal Guardian **Date**

_____ _____

Printed Name of Client's Representative (if applicable) **Representative's Relationship to Client**