2900 Purchase Street
Counseling Center
Spellman G11
Purchase, NY 10577
Phone: (914) 323-5155
Fax: (914) 798-2701

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Patient's Social Security Number** _____

The following specific person/facility is authorized to use or release information about me:

MANHATTANVILLE COLLEGE COUNSELING CENTER

2900 Purchase Street Purchase NY 10577 (914)323-5155

Attn: _____

The following person/facility may receive clinical information about me:

_____

_____

_____

(Name of person or organization, address, phone number, fax number)

The specific information that should be disclosed is:

_____ Intake Assessment _____ Psychiatric Evaluation

_____ Psychological Evaluation _____ Discharge Summary

_____ Other (please specify): _____

The released information is to be used for:

_____ Evaluation and Continuing Treatment _____ Coordination of Care _____ Other: _____

Patient Authorization

I understand that my records may contain information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted infections, and drug and/or alcohol abuse. I give my special authorization for this information to be released. **INITIALS: _____**

1. I understand that the information used or disclosed may be subject to re-disclosure by the person/facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization.
3. I may revoke this authorization at any time by notifying Manhattanville College Counseling Center in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Record, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
5. This authorization expires on _____, 20_____ (or 1 year from when it was signed).

_____ _____

Signature of Individual **Date of Individual's Signature**