Authorization Form for the Release of Confidential Information (rev. 06.12.23)

I, _____ , _____ ,
Full Name of Client **WVU ID Number**

_____ _____ _____
Current Address **Telephone** **Date of Birth**

authorize the WVU Carruth Center staff to: ☐ **release information to**; ☐ **receive information from** ☐ **both**

- ☐ WVU Medicine
- ☐ Office of the University Registrar/Student Financial Support and Services
- ☐ Center for Learning, Advising, & Student Success
- ☐ Office of Student Rights & Responsibilities
- ☐ Residence Life
- ☐ Office of Accessibility Services
- ☐ WVU Athletics
- ☐ WVU CARE Team/Division of Student Life
- ☐ WVU Faculty/Staff Member: _____

_____

- ☐ Other (specify below)

_____
Name of Person and/or Organization

_____
Address

_____
City/State/Zip

_____
Phone and/or Fax

for the following information:

- ☐ Diagnosis, treatment, assessment, and/or consultation for mental health or psychiatric disorders
- ☐ Testing/Evaluation results
- ☐ Medical information related to psychiatric care
- ☐ Dates of appointments and attendance
- ☐ Summary of treatment
- ☐ Recommendations for ongoing care
- ☐ Other (specify below):

_____

for the period of:

- ☐ All dates of treatment
- ☐ Other (specify) _____

for the purpose of:

- ☐ Coordination of care between these providers
- ☐ Transfer of care to another provider
- ☐ Verification of appointment history
- ☐ Coordination of campus resources
- ☐ Confirmation of completion of required program of treatment
- ☐ Other (specify): _____

I understand that my records are confidential and cannot be disclosed without my consent unless required by law. I understand that I have the right to revoke this authorization at any time. However, my revocation will not be effective to the extent that action has already been taken.

I understand that psychological services in the WVU Carruth Center will not be provided to me on the condition of my signing an authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the laws of confidentiality.

This consent will expire at the end of one hundred eighty (180) days, or on: _____
Specified Date

_____ _____
Signature of Client **Date Signed**

_____ _____
Signature of Parent, Guardian or Legal Representative **Signature of Witness**

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided here:_____
_____