SUCCEEDS ADHD Program
Students Understanding College Choices:
Encouraging and Executing Decisions for Success

Department of Psychology
University of Maryland
College Park, Maryland 20742

Client Authorization to Release Health Records/Information

Section 1: Client Information

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

UID: _____

Section 2: Client Authorization

I hereby authorize the disclosure and/or use of my protected health information [check as appropriate]:

☐ **FROM or** ☐ **TO**	☐ **FROM or** ☐ **TO**	☐ **FROM or** ☐ **TO**
University of Maryland SUCCEEDS Clinic Attn: Andrea Chronis-Tuscano, Ph.D. 2109 Biology/Psychology Building College Park, MD 20742 Phone: (301) 405-4606	Name: _____ Address: _____ _____ Phone: _____ Fax: _____ (if preferred method of delivery)	Name: _____ Address: _____ _____ Phone: _____ Fax: _____ (if preferred method of delivery)

Section 3: Information to be Disclosed; Method of Disclosure

DATES OF RECORDS/INFORMATION

From: (insert date)_____To: (insert date) _____

TYPES OF RECORDS/INFORMATION [check as appropriate]

- ☐ Mental health records
- ☐ Entire medical record
- ☐ Statement for insurance claims and other billing purposes
- ☐ Prescription/pharmacy records
- ☐ Other (please specify):

My initials below authorize inclusion of the following types of sensitive information pertaining to:

- ☐ Mental health*:_____
- ☐ Drug/alcohol use:_____
- ☐ Pregnancy: _____
- ☐ HIV/AIDS: _____
- ☐ Communicable diseases health information, even if checked above.

*You *must* include your initials for disclosure of mental

- ☐ Abuse** (sexual/physical/mental):

** UMD employees are mandated reporters of child abuse

If the information/records include(s) records or information from another health care provider or entity, that information: [check one] □ **should** or □ **should not** be released under this Authorization.

METHOD OF DISCLOSURE

Please release my records/information via [check as appropriate]:

□ Mail □ Fax* □ In-person pick-up by patient □ Verbal

* Please note that faxing may compromise your privacy.

Section 4: Purpose of Authorization

The authorization is for the following purpose [check as appropriate]:

□ Personal use □ Patient care □ Insurance

□ Legal □ Parent/guardian use

□ Other (please specify): _____

Section 5: Authorization Expiration

This Authorization will expire on [insert date]_____or one year from the date the Authorization is signed, whichever is earlier.

Section 6: Client Acknowledgement – Please Read Carefully

FERPA: As a student, your records, including health records, are protected by the federal Family and Educational Privacy Act ("FERPA") rather than the Health Insurance Portability and Accountability Act ("HIPAA"). FERPA and HIPAA have different exceptions that allow for the disclosure of information without consent.

Confidentiality: All SUCCEEDS records are confidential to the extent permitted by federal and state law and University policy. I understand and acknowledge that there are exceptions to confidentiality, as required by law, including but not necessarily limited to: (1) when I have signed an Authorization to release records to specified individuals or organizations; (2) when there is a court order for the release of my records; (3) when I am perceived by SUCCEEDS staff to be a danger to myself or others; (4) when I am suspected of abusing children or other vulnerable individuals; and (5) when I report that I was physically or sexually abused before the age of 18.

Re-Disclosure: I understand that when my records/information are disclosed pursuant to this Authorization to someone who is not required to comply with federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.

Revocation: I further understand that I retain the right to revoke this Authorization at any time, if I do so in the manner set forth below. I understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my information have already acted in reliance on this Authorization.

In order for my revocation to be effective, it ***must be in writing*** and ***must include the following***: (1) the client's name, address, and UID; (2) sufficient information to identify this Authorization, including the date and recipient of records/information; (3) the client's desire to revoke this Authorization; (4) the intended date of the revocation, if later than the receipt of the revocation; *and* (5) the client's signature. All revocations must be sent in writing to the SUCCEEDS Clinic at the address provided above. A revocation is not effective until the date it is received by SUCCEEDS or the date specified in the revocation, whichever is later.

I AUTHORIZE THE USE AND/OR DISCLOSURE OF MY RECORDS/INFORMATION AS DESCRIBED ABOVE. I HAVE READ THE CONTENTS OF THIS AUTHORIZATION AND I FULLY UNDERSTAND AND ACCEPT ITS TERMS.

Client Name: _____

Client Signature: _____

Date: _____

If Client is under the age of 18

Parent/Guardian Name: _____

Parent/Guardian Signature _____

Date: _____

FOR CLINIC USE ONLY

Report(s)	Report(s)'s Date	Supervisor Signature	Sent