University of Dubuque
Smeltzer-Kelly Student Health Center
AUTHORIZATION FOR RELEASE AND/OR RECEIPT OF CONFIDENTIAL INFORMATION

Student: ____ DOB: ____________________

I hereby authorize the Staff of the Smeltzer-Kelly Student Health Center to release and/or obtain the information indicated below regarding the above-named client with:

Name of Person/Agency: ______________________________________ Phone #: ____________________

Complete Address: ____

The Information being released will be used for the following purpose(s):

_______ Planning and Implementation of my Individual Services

_______ Referral of New Services

_______Coordination/Monitoring of Services

_______Other (Specify): ____________________

____

Information to be Released and/or Obtained:

Dates of Services: ____________________________

_______Entire Record

_______Treatment Plans

_______Medical History

_______Discharge Reports

_______Lab/Radiology

_______Educational/Vocational Records

_______Progress Reports

_______Assessments

_______Other: ____

This authorization is effective the duration that the Student is a patient of Smeltzer-Kelly Student Health Center or until (____________________). This authorization will automatically be revoked one (1) year after discharge.

This Information has been disclosed to you from records protected by Federal and Iowa State Confidentiality Rules CFR 42, Part 2, Iowa Chapter 228 of the Iowa Code. These 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 as otherwise permitted by such regulations. A general authorization for the release of medical and other information is NOT sufficient for this purpose. Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient. Smeltzer-Kelly Student Health Center will not make the signing of the Release of Information a condition of your treatment, enrollment, or eligibility for services.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: **PLEASE INITIAL**

_______ Substance Abuse

_______ Mental/Brain Health Treatment

_______ HIV Related Information

Student Signature: ______________________________________ Date: ____________________

In order for this information to be released, you MUST sign here & below

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by the source facility. I understand that this authorization is voluntary. This form does not authorize re-disclosure of medical information beyond the limits of this consent. Providing a written statement to the recipient named above and to Smeltzer-Kelly Student Health Center. I also understand that any information released prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

______________________________________ ______________________________________

Student Signature Date Witness Signature Date