Counseling Center

Anderson University Center, Suite 300, Tacoma, WA 98447
Phone: (253) 535-7206, Fax: (253) 536-5124

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

_____ _____
Student's Full Name Student's Date of Birth (MM/DD/YYYY)

I authorize the Pacific Lutheran University Counseling Center to: (***please initial Yes or No***)

Yes	**No**	
_____	_____	Disclose
_____	_____	Obtain
_____	_____	Exchange

Protected Health Care information with:

_____
Name of Health Care Organization and/or Individual

_____ _____
Street Address Telephone Number

_____ _____ _____ _____
City State Zip Code Fax Number

Reason for disclosure or exchange of information: ***(please initial appropriate boxes***)

_____ Facilitate treatment _____ Summarize treatment _____ Other: _____

Information to be obtained/disclosed: (***please initial yes or no***)

Yes	**No**	
_____	_____	Intake or HPI
_____	_____	Progress Notes
_____	_____	Treatment Plan
_____	_____	Psychological Testing
_____	_____	Medications
_____	_____	Labs
_____	_____	Other: _____

If the information to be obtained/disclosed contains any of the information listed below, I understand and agree that this information (below) can be obtained/disclosed if I initial "Yes" in the space next to the type of information: (***please initial yes or no***)

Yes	**No**	
_____	_____	Drug/alcohol diagnosis, treatment or referral information
_____	_____	Mental health information including provider notes
_____	_____	HIV/AIDS information
_____	_____	STI information

This Authorization expires on _____(date) or upon occurrence of the following event that relates to the information about me: _____, or completion of treatment.

- I understand that the information obtained or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. I also understand that federal or state law may restrict redisclosure of drug/alcohol, mental health information.
- You may revoke this authorization in writing at any time by completing the Counseling Center's Revocation of Authorization Form.
- A copy of this authorization is as valid as the original. Student has a right to a copy of this authorization.

_____ _____
Student's Signature Date

Reviewed and approved by legal 02/22/2018 sjl