Counseling for Faculty and Staff
Institute for Health and Human Services
Appalachian State University
ASU PO Box 32102
Phone: 828-262-4951 Fax: 262-6766

# Authorization for Release of Information

This form when completed and signed by you authorizes us to release protected health information from your clinical record to the person or agency you designate.

I authorize Counseling for Faculty and Staff to disclose or exchange the following types of protected health information from my clinical record:_____

_____.

This information should only be disclosed to or exchanged with _____

_____

_____.

The purpose of this disclosure or exchange is_____

_____.

This authorization shall remain in effect until _____(not to exceed one year).

You have the right to revoke this authorization, in writing, at any time except to the extent that action based on this consent has been taken.

I understand that Counseling for Faculty and Staff cannot refuse to provide services to me if I refuse to sign this form.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and, therefore, no longer be protected under the Privacy Rule of the federal Health Insurance Portability and Accountability Act (HIPAA).

_____ _____
Signature of Client Date

_____
Name of Client