SEWANEE
THE UNIVERSITY OF THE SOUTH

DEAN OF STUDENTS OFFICE

Authorization to Release/Obtain Information

Please print

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

☐ I authorize the Dean of Students Office to RELEASE information to: **AND/OR** ☐ I authorize the Dean of Students Office to OBTAIN information from:

_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone #/ Fax # (including area code)	_____ Phone #/ Fax # (including area code)

PURPOSE OF THIS REQUEST: (check one) ☐ Healthcare ☐ Personal ☐ Academic ☐ Other

TYPE OF RECORDS AUTHORIZED: ☐ Psychiatric/Psychological Evaluation and/or Treatment
☐ Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate):

☐ Attendance/Participation ☐ Assessments ☐ Progress Notes
☐ Disabilities/Accommodations ☐ Discharge/ Treatment Summary ☐ Recommendations/Treatment Plans
☐ Verbal Consults ☐ All Clinical records/information (I understand that the information may contain psychiatric/ psychological, alcohol/drug abuse, and/or HIV information and I expressly consent to the release of the information)
☐ Other: _____

My Authorization will expire: ☐ When I am no longer a student of Sewanee: The University of the South
☐ One Year from this date ☐ Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to the Dean of Students Office, except where a disclosure has already been made due to my prior authorization.
- I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure.
- If I have authorized the disclosure of information to a recipient who is not subject to HIPAA, then the recipient may re-disclose the information and it may no longer be protected under privacy laws.
- I freely give this consent and I do hereby release and hold harmless the University from any and all liability or damage, which may result from the disclosure of information herein authorized.

Signature of Student: _____ Date: _____

Student has been provided a copy of this authorization: ☐ Provided ☐ Declined _____ Staff initials

8.15.14