NC STATE UNIVERSITY

Department of Student & Community Standards
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(919) 515-2963 Office
(919) 513-4829 Fax
http://go.ncsu.edu/NCSUcares

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name ________________________________ **Date of Birth** ___ / ___ / ______ **NCSU ID:** _____________

I ____ hereby authorize ____
(Client or Personal Representative) *(Provider/Agency)*

to disclose specific health information from the records of the above named client to:

- ❑ **Department of Student and Community Standards**
- ❑ **NCSU Student Behavioral Assessment Team** (a multi-disciplinary team comprised of representatives from the Department of Student and Community Standards, Offices of Student Conduct, Housing, Counseling, Campus Police, Environmental Health and Safety, and Legal Affairs. Its purpose is to enhance the safety of students and other members of the University Community by reviewing situations that raise concerns about safety).

For the specific purposes of: <u>case management and coordination of care to include sharing with other University departments as needed</u>.

Specific information to be disclosed includes:

- ❑ **Appointment verification**
- ❑ **Treatment progress and recommendations**
- ❑ **Concerns regarding the client's wellbeing or safety for self or others**
- ❑ **Any**
- ❑ **Other**: ____

Furthermore, I request and authorize the Department of Student and Community Standards at North Carolina State University to release any information back to ____ in order to facilitate continuity of care. *(Provider/Agency)*

I understand that this authorization will expire on the following date, event or condition: ______________________________
____.

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I revoke authorization, I must do so in writing. Requests to revoke this authorization should be directed to the above named agency/provider.

I understand that any private health information disclosed under the authorization may no longer be protected by federal privacy regulations; however, if this information is protected under the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information related to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, or psychological or psychiatric conditions, this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for assistance through NC State University or the Department of Community and Student Standards.

I further understand that I may request a copy of this signed authorization.

_________________________________ _____________ _________________________________
(Signature of Client) *(Date)* *(Witness)*