CAPS

STUDENT WELLNESS CENTER
Student Counseling & Psychological Services (CAPS)
4505 Maryland Parkway
Box 452005
Las Vegas, Nevada 89154-2005
(702) 895-3627 · FAX (702) 895-0149

Account No.

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

(For purposes other than treatment, payment or health care operations)

It may *take 5 business days and no more than 30 days* to process your request. Cost of copies is $.60 per page. A copy of authorization is available upon request.

Name: ____ **DOB:**____________________ **NSHE #:**____________________

Phone No. to contact you: ___________________________________

I HEREBY AUTHORIZE INFORMATION TO BE RELEASED:

FROM:	**TO:**
Name/Agency: ______________________________	**Name/Agency:** ______________________________
Address: ______________________________	**Address:** ______________________________
______________________________	______________________________
Ph. No. ______________ **Fax No.** ______________	**Ph. No.** ______________ **Fax No.** ______________

☐ **Allow mutual disclosure between agencies listed above** ☐ **Allow verbal disclosure only to the agency listed above**

PURPOSE FOR RELEASE: ____

INFORMATION TO BE RELEASED:

________ Psychiatric Evaluation ________ Intake Summary ________ Psychological Assessment

________ Treatment Plan ________ Progress/Case Notes ________Termination Summary

________ General Treatment Summary

________ Other: (Specify)____

CONSENT FOR INFORMATION TO BE FAXED: ☐ Yes ☐ No

I understand that my records may be faxed and I give my consent to transmit my records via facsimile with my understanding that confidentiality cannot be guaranteed, despite rigorous precautions to safeguard confidentiality.

Date of last visit to the agency releasing information (Month & Year):____

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization ***expires one year from date of signature*.**

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations. I understand if I do not authorize the release of my full health record, the recipient will be notified that only a limited health record is provided per patient request. Provider will not require me to sign an authorization as a condition of further treatment. I understand that the information used or disclosed pursuant to this authorization should not be re-disclosed without the written authorization of the student. The university, the Student Wellness Center (Student Counseling and Psychological Services and Student Health Center), its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

DOCUMENT MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC IF NOT SIGNED AT THE STUDENT WELLNESS CENTER

Signature of Student or Legal Representative: ____ **Date**: ______________

Witness to Signature (SW Staff): ____ **Date**: ______________

Print Name of Legal Representative: ________________________________**Phone No.** ____________________

Relationship to student: □ Parent □ Legal Guardian (Attach documentation of guardianship)

Date Disclosed:______________ PHI Sent to Requestor Via: ☐ Fax ☐ Mail ☐ Pick Up Box ☐ Given to Patient

Pages Prepared:______________ Type of PHI Disclosed: ________________________________

PHI Xeroxing Charges: $ Staff Initials & Title:

Revised 10/17
Reviewed 7/20