Dr. Bob Smith Health Center
Counseling Services
P.O. Box 750195
Dallas, TX 75275
Phone 214-768-2277 Fax 214-768-2911

Authorization for Release of Confidential Protected Health Information (PHI)

Printed Full Legal Name: ____Date of Birth: _______________

I hereby authorize SMU CAPS to obtain information from and/or release information to the person and/or agency indicated below for the purpose of treatment or___________________________________.

Name of person and/or agency: ____

Mailing address: ____

____

Phone: _________________________________ Fax: ________________________

By checking below, I specifically authorize the release of the following information:

PSYCHOTHERAPY/COUNSELING & TESTING		PSYCHIATRIC/MEDICAL RECORDS	
____	*Summary of care	____	*Summary of Care
____	Progress Notes	____	Progress notes
____	Assessments (Diagnosis, Testing, Reports)	____	Assessments (Diagnosis, Testing, Reports)
		____	Psychiatric (Notes, Medications, Referrals)
		____	Drug and alcohol information
		____	HIV/AIDS related test results & information
____	Information specific to:________________	____	Information specific to:________________

*I understand that the information to be used or disclosed if this item is checked may include information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral heath or psychiatric care.

Specific conditions or limitations of the information to be released include:____________________________

____.

Time period for this release of protected health information is from ________ to ________.

I release and agree to hold harmless SMU and its trustee, officers, psychiatrists, psychologists, other health care providers, and other employees from any and all liability associated with the release of my confidential patient information in accordance with this authorization. I understand that SMU is not responsible for use or redisclosure of information by third-parties.

I understand that my records are protected under federal confidentiality (including alcohol and drug disclosure restrictions) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The conditions of this form have been explained to me and my questions have been satisfactorily answered. I understand that I am not obligated to sign this consent form, and I may revoke this authorization at any time with the exception of action already taken based on my previous approval.

_______________________________ ____________________________________
Signature of Patient/Client Name *(Print name)*

_______________________________ ____________________________________
Signature of Witness Name *(Print name)*

_______________________________ ______________________ __________
Date of release Date release revoked Initials

6/28/07