Bates

Counseling and Psychological Services
31 Campus Avenue, Lewiston, ME 04240
Phone: 207-786-6200
FAX: 207-786-8219

Authorization for Release/Obtaining of Student Mental Health Information

Student Name:_____ Today's Date:_____/_____/_____
Student ID#: _____ Date of Birth:_____/_____/_____
Phone: _____

I hereby request the release/obtaining of the following for the purpose of provision, coordination, or management of mental health or associated services:

__Treatment Plan/recommendations
__Intake Assessment
__Progress Notes
__Treatment Summary
__Crisis Session Notes
__HIV/AIDS Record
__Psychiatric Evaluation
__Psychological Assessment Report
__Attendance Record
__Medication Record
__Substance Use Record
__Bates Record: Conduct Concern
__Bates Record: Alcohol, Tobacco, and Other Drug Concern

Other (Please Specify):_____

Exceptions to Release of Information*:_____

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*Treatment records regarding substance abuse and HIV/AIDS are protected under Federal regulations. You have the right to refuse to release this information. All other information regarding mental health treatment may be withheld or limited, except as allowed or required by law. Limiting information may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.

This release of information is between Bates Counseling and Psychological Services and the following individual(s)/agency/organization:

Name(s):_____

Phone:_____ FAX:_____
Email:_____

Address:_____
_____

__Obtain Records/Information* **__Disclose Records/Information***
*It is assumed that communication of information is permitted via phone, email, regular mail, verbally, fax, and/or in person ***unless*** limited by the client to one or more specific mediums.

By signing this authorization, I acknowledge:

This release of information is voluntary and I am not required to sign this form to receive any mental health services. This form will be retained as part of my treatment record at Bates Counseling and Psychological Services (CAPS). I may review and copy the information that is released upon request.

This release of information is authorized from ___/____/_____ to ___/_____/_____.
I may revoke this authorization at any time prior to its expiration date by written notice to either party to which disclosure has been authorized. Any such revocation will not have any effect on actions taken before the revocation.

I understand that health information held by CAPS is considered part of my "treatment record" under FERPA as a protected medical/mental health record and that by reviewing or disclosing this information, I am making it part of my "education record" under FERPA. This means that records I have reviewed or disclosed may be subsequently disclosed without my consent as authorized by FERPA.

I understand that CAPS may decline to disclose information if it is determined by the provider that such disclosure would be detrimental to my health. I will be notified if any such records are withheld.

I_____DO ____DO NOT want a copy of this authorization.

_____ _____/_____/_____
Signature of Student Date

_____ _____
Printed Name Student ID

_____
Witness