**University of Rochester Psychological Service Center (URPSC)**
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# AUTHORIZATION FOR RELEASE / DISCLOSURE OF BEHAVIORAL HEALTH AND/OR MEDICAL INFORMATION

Client Name (print): _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Phone: (_____) _____

**This authorization allows URPSC to:**

☐ **SEND** copies of your record to (or discuss your information with) the provider / person / organization below
☐ **RECEIVE** copies of your record to (or discuss your information with) the provider / person / organization below

Provider / Person / Organization: _____

Address: _____

City, State, Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

**Purpose of this request:**

☐ Coordination with care providers (e.g., PCP, Psychiatry)
☐ Consultation or supervision
☐ Legal or forensic concerns
☐ Academic services or accommodations
☐ Other (describe): _____

**Type of information or records requested:** (check all that apply)

☐ General behavioral health records
☐ General medical health records
☐ Academic records
☐ Psychological testing and assessment
☐ Biopsychosocial intake and progress notes
☐ Case formulation and treatment planning
☐ Other (describe): _____

**Authorization valid for:** (if no selection is made, authorization is valid only for this request)

☐ This request only
☐ Duration of treatment
☐ One year from the date of this authorization OR until (insert date): _____
☐ This request and for records of any future treatment of the type described above until (insert date): _____
☐ Other (describe): _____

**I understand that:**

- Signing this form is my choice. My decision will not affect my ability to get services at URPSC. But if I do not allow URPSC to share information with others who help care for me, it may limit the full range of care I can receive.
- At any time, I can change my mind and cancel this form by sending a written request to the address at the top of this form. If I cancel this form, the change will not apply to information that has already been shared.
- Once information is shared with another person or organization, it may no longer be protected under federal or state privacy laws, and the person or organization who receives it may share it again.
- URPSC is a training clinic that follows University privacy policies, NYS law, and professional ethics to protect client information.

Signature of Client or Representative: _____ Date: _____

Relationship to Client (if signing as authorized representative): _____

*Distribution: Original to URPSC Client Record. Copy to client as required. This authorization must be retained for minimum of six years beyond the validation limits.*
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