Robert Morris University
UNIVERSITY COUNSELING CENTER

6001 University Blvd
Moon Township, PA15108
Campus Fax: 412-397-2202

Authorization for Release of Information - ADHD

Name:	**Date of Birth:**
Address:	**City, State, Zip**
Student ID#	**Student Phone Number**

X I authorize the University Counseling Center to release information **to:**

AND/OR

X I authorize the University Counseling Center to obtain information **from:**

Name of Provider or Facility		*Name of Provider or Facility*
Address		*Address*
City, State, Zip Code		*City, State, Zip Code*
Phone#/Fax#		*Phone#/Fax#*

PURPOSE OF THIS REQUEST: (check one) **X Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

TYPE OF RECORDS AUTHORIZED:
X Psychiatric/Psychological Evaluation and/or Treatment
☐ **Drug/Alcohol Evaluation and/or Treatment**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

X Assessments	☐ Progress Notes	☐ Laboratory Test Results
X Diagnostic Impression	☐ Discharge Summary	☐ Treatment Plans
☐ Treatment Summary	**X** Treatment Recommendations	**X** Other **Medication History**

☐ **One-time Use/Disclosure:** I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

My authorization will expire:
☐ When the requested information has been sent/received.
☐ 90 days from this date. ☐ Other: _____

X Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:
X When I am no longer receiving services from the University Counseling Center.
☐ One year from this date. ☐ Other: _____

I understand that:
- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a ***written*** notification to the University Counseling Center, except where a disclosure has already been made in reliance on my prior authorization.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.

Signature of Student or Representative: _____ Date: _____

Relationship to Student (*if requester is not the student)*: ☐ Parent ☐ Legal Guardian ☐ Other: _____

Patient or Representative has been provided a copy of this authorization: _____
Staff member providing copy