Authorization to Release Protected Information

This form authorizes the release of protected information for: _________________________________________

(1) Records (check one): ☐ My OWN  ☐ My CHILD’s

(2) One-way (check one) or two-way (check both):
☐ FROM the UNC Department of Psychology Community Clinic (UNC-DPCC)
☐ TO the UNC Department of Psychology Community Clinic (UNC-DPCC)

(3) Individual or agency to provide and/or receive information (based on above selection)
_____________________________________________________________________________
_____________________________________________________________________________

(4) Reason for request: ☐ Treatment  ☐ Assessment  ☐ Coordinate Care  ☐ Referral
Other (please specify): ________________________________________________________

(5) Info to be provided or released: ☐ Summary  ☐ Full Clinical Record  ☐ Assessment Report (if applicable)
Other (please specify): ________________________________________________________

(6) Authorization Expires: ☐ When no longer an active client at UNC-DPCC  ☐ Other: ____________

I UNDERSTAND that:
• I may revoke this authorization at any time, but I must do so in writing and send my revocation to the
  Clinic Manager at the Davie Hall address listed in the header above. The revocation will not be
effective to the extent that the information has already been disclosed. Information used or disclosed
pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by
applicable federal or state privacy rules.
• Records provided for purposes other than treatment may result in charges.

Client Signature: ____________________________ Date: ________________

FOR MINORS
Parent/Guardian: ____________________________ Date: ________________

Witness Signature: ____________________________ Date: ________________