MORAVIAN COLLEGE

COUNSELING CENTER
1200 Main Street, Bethlehem PA 18018
P: (610) 861.1510 F: (610) 625.7935

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client's Name: _____ Local Phone: _____
MoCo ID#: _____ Date of Birth: _____

I hereby authorize Moravian College Counseling Center to obtain / release information pertaining to my evaluation and / or treatment for coordination of treatment and continuity of care to/from:

Name:_____ Relationship:_____
Address:_____
City:_____ State:_____
Phone:_____ Fax:_____

Name:_____ Relationship:_____
Address:_____
City:_____ State:_____
Phone:_____ Fax:_____

Name:_____ Relationship:_____
Address:_____
City:_____ State:_____
Phone:_____ Fax:_____

Such information as is exchanged shall be used solely for the purpose of providing for my treatment and/or care. The permission for the release and/or receipt of confidential information expires:

☐ in 30 days ☐ at the start of the next semester ☐ 30 days after discharge from treatment

Client Signature: _____ Date: _____

Witness Signature: _____Date: _____

I understand and agree that a copy of this authorization (e.g. electronic copy, fax, or photocopy) shall have the same force as the original.

I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to the Counseling Center.

However, my revocation will not be effective if the Counseling Center has already shared the information specified in the authorization with the designated recipient(s).

I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

I understand that my counselor generally may not condition psychological services upon my signing this authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that I have the right to inspect the disclosed mental health information at any time.

I understand that state and federal laws concerning mental health treatment information prohibit re-disclosure by the recipient of the information specified in this authorization, when the recipient is covered by federal or state privacy regulations. I also understand that if the recipient is **not** covered by federal or state privacy regulations, the recipient may choose to share this information with others and Moravian College Counseling Center has no control over this re-disclosure. Moravian College offices that are not governed by federal or state privacy regulations pertaining to mental health information include all campus offices and employees except the Counseling Center and the Health Center.