

BRIGHAM YOUNG
UNIVERSITY
IDAHO

AUTHORIZATION FOR RELEASE OF INFORMATION

Notice: Confidential mental health and medical information generally cannot be released to others without your consent. Do not sign this release form unless it is filled out completely and you believe that the release of this information is in your best interests.

Name: _____ Date of Birth: ____/____/____
Address: _____ Phone: (____) ____-____

I do hereby authorize and direct the **BYU-Idaho Counseling Center** to

(Check ALL options that apply)

☐ Exchange information with:
(Allow **verbal** communication)

☐ Release records to:
(Send records)

☐ Request records from:
(Receive records)

Name: _____

Address: _____

Fax (**Required**): _____ Phone: _____

Relationship to Client (**Check ONE only**):

☐ Self ☐ Parent/Guardian ☐ Counseling Office ☐ Medical Provider ☐ Other: _____

Requested Records (**Check ALL options that apply**):

☐ All Counseling Records

☐ All Medical Records

☐ Letter from Provider

☐ Most Recent Note

☐ Diagnosis

☐ Other (please specify): _____

I am requesting records regarding myself including, but not limited to, professional opinions, reports or examinations, tests, treatment, drug and alcohol screening, sexually transmitted disease testing, diagnosis, and prognosis pertaining to all dates I was seen at the BYU-Idaho Counseling Center unless otherwise specified.

Only complete this section if you are requesting your own records:

I would like my records sent to me by (**Check ONE only**):

☐ Pick-Up

☐ Us Mail
(to the address listed above)

☐ Email

I wish to receive my records by
e-mail and understand it is **NOT** confidential.

This authorization will expire in 120 days from the date signed.

I understand I may revoke my authorization at any time by providing a written request for such, except as to actions that have been taken in reliance upon it. I also understand a photocopy of this authorization may serve as an original.

Signed: _____

Date: _____

Witness: _____