

AUTHORIZATION FOR RELEASE OF INFORMATION

Your Privacy Matters: Your mental health and medical records are strictly confidential. We cannot and will not share them with anyone without your permission. Please ensure this form is fully filled out before signing.

STEP 1: Student Information

Full Name: _____ Date of Birth: _____

Phone: _____ Mailing Address: _____

[Click here to attach Photo ID](#)

STEP 2: Flow of Information:

- ☐ **Talk & Verbal Updates (Exchange information):** Allow the Counseling Center and the person/organization below to **verbally talk back and forth** to coordinate my care. (No written records will be sent or requested)
- ☐ **Send Records TO (Release):** Send copies of my counseling records **TO** the person/organization below.
- ☐ **Get Records FROM:** Ask for and receive past records **FROM** the person/organization below.

STEP 3: Outside Person or Organization: *Please list the contact details for the person or office you checked in Step 2.*

Name of Person or Organization: _____

Relationship to Student: *(Check ONE only)*

- ☐ Self ☐ Parent / Guardian
- ☐ Medical Provider / Doctor ☐ Other: _____
- ☐ Outside Counselor / Office

Phone Number: _____ Fax Number: _____ (required for requesting or releasing written records)

Mailing Address: _____

STEP 4: What information do you want to share? *Check ALL options that apply:*

- ☐ All Counseling Records ☐ Most Recent Progress Note
- ☐ All Medical Records ☐ Diagnosis
- ☐ Other *(please specify)*: _____

Reason for this request **(Required)**: _____

(Examples: Continuity of Care, Coordination of Treatment, Personal Use/Review, Academic Accommodations, etc.)

Delivery Method for personal records - only complete if you are requesting personal copies of your own records*If you asked for records to be sent directly to you, how would you like to receive them? (Check ONE only)*

- ☐ Pick up in person
- ☐ Send via US Mail *(Will be sent to the address you provided in Step 1)*
- ☐ Email *(Note: Email is NOT considered a secure or confidential delivery method, see digital submission acknowledgement)*

Email Address: _____

STEP 6: Review and Sign

By signing below, I authorize the BYU-Idaho Counseling Center to share the records specified above. I understand this includes, but is not limited to professional opinions, reports, exams, tests, treatment notes, drug/alcohol screenings, sexually transmitted disease testing, diagnoses, and prognoses for all dates I was seen, unless otherwise specified.

- **Expiration:** This authorization will automatically expire 120 days from the date signed.
- **Cancellation:** I understand I can cancel (revoke) this permission at any time by providing a written request to the Counseling Center, except for actions that have already been taken.
- **Photocopies:** A photocopy or scan of this signed form may serve as an original.
- **Processing Time:** The BYU-Idaho Counseling Center processes records as quickly as possible but reserves the right to take up to **45 days** from the receipt of this form to complete requests.

Note: Under certain circumstances, records may not be eligible for release. In accordance with FERPA, these records may be made available for your review and inspection in person within 45 days of this request.

- ☐ **Digital Submission Acknowledgment:** I understand that standard email is not secure, and I accept the privacy risks of emailing this completed form and/or receiving my own records via email.

Student Signature: _____ Date: _____

[Submit Form](#)