

University Counseling and Testing Center (UCTC)
300 Alumni Circle, Mobile, AL 36688/(Telephone) 251-460-7051/(Fax) 251-460-7492

Authorization for Release of Protected Health Information (PHI)

NAME: _____ DATE OF BIRTH ____/____/____
ADDRESS _____
PHONE NO. (____) _____ J NUMBER _____

I hereby authorize the UCTC or any of its staff to use, disclose, or obtain by any acceptable means, including fax, phone, or email my Protected Health Information.

Check the one that applies: Use PHI Disclose PHI Obtain PHI

Dates of records to be released: _____

PHI to be used, disclosed, or obtained:

Student Disability Services Dean of Students Office	Treatment Provider (<i>fill in information below</i>) Parents/Other Family (<i>fill in information below</i>) OTHER _____
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RECIPIENT'S NAME: _____ ADDRESS: _____
PHONE: _____ FAX: _____

The purpose of this use, disclosure or obtainment is:

At the request of the client	Letter of Support
Coordination/Continuity of Care	OTHER _____

Signature of Client or Client's Legal Guardian

Date

Printed Name of Client's Representative (if applicable)

Representative's Relationship to Client