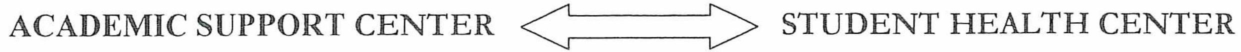
AMERICAN UNIVERSITY



AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION

AS SPECIFIED IN THE DISTRICT OF COLUMBIA MENTAL HEALTH INFORMATION ACT OF 1978

ACADEMIC SUPPORT CENTER ⟷ STUDENT HEALTH CENTER

I hereby authorize members of the Academic Support Center staff and Student Health Center staff to disclose the following information to each other (check all that apply):

- ☐ Administrative information (e.g., name, age, sex, address, identifying numbers, dates and character of service).
- ☐ Treatment information (e.g., summary of initial concerns, course of treatment, termination of treatment, etc.).
- ☐ Other (describe) ____________________

The purpose for which the information may be used is (check all that apply):

- ☐ Consultation regarding my psychiatric, medical, and educational needs
- ☐ Other (describe) ____________________

Signature: ____________________ **Witness:** ____________________

Print Name: ____________________ **Signature Date:** ____________________

Date, event, or condition upon which this authorization expires (not to exceed 60 days): ____________________

Renewal of Authorization (Needed every 60 days):

Signature: ____________________ Witness: ____________________

Print Name: ____________________ Signature Date: _______ Expiration Date: _________

Signature: ____________________ Witness: ____________________

Print Name: ____________________ Signature Date: _______ Expiration Date: _________

Signature: ____________________ Witness: ____________________

Print Name: ____________________ Signature Date: _______ Expiration Date: _________

Signature: ____________________ Witness: ____________________

Print Name: ____________________ Signature Date: _______ Expiration Date: _________

Client's Right of Inspection of Records and Right to Revoke Authorization to Disclose Mental Health Information

(a) I understand that I may revoke this authorization, except (l) where authorization is executed in connection with obtaining a life or noncancellable or guaranteed renewable health insurance policy, In which case the authorization will be specific as to its expiration date which shall not exceed 2 years from the date of the policy; (2) where authorization is executed in connection with obtaining any other form of health insurance in which case the authorization will be specific as to its expiration data which shall not exceed 1 year from the date of the policy.

(b) I understand I have a right to inspect my record of mental health information upon proper written request.

TO AUTHORIZED RECIPIENTS OF CONFIDENTIAL INFORMATION: The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (sections 7-1201.01 to 7-1207.02). Disclosures may only be made pursuant to a valid authorization by the client or as provided in the title III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.

4400 MASSACHUSETTS AVENUE NW, MARY GRAYDON CENTER 214, WASHINGTON DC 20016-8150 PHONE: 202-885-3500 FAX: 202-885-1397