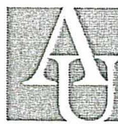

AMERICAN UNIVERSITY STUDENT HEALTH CENTER

AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION

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

I hereby authorize the following information (check all that apply) :

YES	NO	Type of information
☐	☐	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 : ISSS, DOS, ASAC, FINANCIAL AIDE, AU Office Party, Outside Party

To be shared between ____________________

Tel.No.: ____________________ FaxNo.: ____________________

AND : AMERICAN UNIVERSITY— Student Health Center
4400 Massachusetts Avenue, NW—McCabe Hall 1st Flr.
Washington, DC 20016

To release all Psychiatric Records except information pertaining to:

____

____

____

Date, event or condition upon which this authorization expires (not to exceed 365 days): ____________________

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 (1) where authorization is executed in connection with obtaining a life or non cancellable or guaranteed renewable health insurance policy, in which case the authorization will be specific as to its expiration data 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.

Signature: ____________________ Witness: ____________________

Print Name: ____________________ Date: ____________________

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. Disclosures may only be made pursuant to a valid authorization by the client." (Section 6-2004, 1978 District of Columbia Mental Health Information Act.)

4400 MASSACHUSETTS AVENUE NW, MCCABE HALL, WASHINGTON DC 20016, PHONE: 202-885-3380 FAX: 202-885-1222

Revised 7/22/2019