Client ID# _____

UND University Counseling Center
UNIVERSITY OF NORTH DAKOTA

Stop 9042
Grand Forks, ND 58202-9042
Phone: (701) 777-2127; Fax: (701) 777-4189

_____ _____
Legal Name of Client (Last, First, MI) Address

_____ _____/_____/_____ _____
Telephone Date of Birth City State Zip

The above-named individual authorizes the UND University Counseling Center to exchange, release and/or receive, as described below, confidential information to/from:

_____ _____
Name/Organization Address

_____ _____ _____ _____
Telephone Fax Relationship City State Zip

Circle the "Yes" or "No" of information to be released/received for each item.

INFORMATION TO BE RELEASED by UCC	INFORMATION TO BE RECEIVED by UCC
Yes No Termination Summary/Planning	*Yes No* Termination Summary Planning
Yes No Intake Assessment	*Yes No* Intake Assessment
Yes No Chemical Dependency Evaluation	*Yes No* Chemical Dependency Evaluation
Yes No Treatment/Plans Recommendations	*Yes No* Treatment/Plans Recommendations
Yes No Progress in Treatment	*Yes No* Progress in Treatment
Yes No Psychological/Psychiatric Consults	*Yes No* Psychological/Psychiatric Consults
Yes No Acknowledgement of Client's Access of Service	*Yes No* Acknowledgement of Client's Access of Service
Yes No Pertinent information related to behavioral or chemical usage patterns	*Yes No* Pertinent information related to behavioral or chemical usage patterns for collateral data gathering purposes
Yes No Other: _____	*Yes No* Other:_____

Purpose: The purpose of this release is to facilitate the assessment, treatment planning, and discharge planning regarding the client who has accessed the UND Counseling Center to evaluation/treatment services.
_____ Other (Specify): _____

Information may be communicated verbally, in writing, and/or by facsimile. Please do not use e-mail. Confidentiality cannot be assured.

Effective this date: _____ to expire _____unless revoked by me.
Note: This is authorization, except for action already taken, can be revoked at any time.

NOTICE: Further disclosure of confidential information without the specific written consent of the person to whom it pertains is prohibited by state and federal statutes.

NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS: this information has been disclosed to you from records protected by Federal confidentiality rules 42 CFR part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that information in confidential records cannot be released without my written consent unless otherwise provided for in legal statutes and judicial orders. I understand that in the event I am authorizing the disclosure of my treatment information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal law. My signature below indicates that I understand the conditions of this release and that I give my authorization voluntarily and I am aware I will be provided a copy of this release of information upon request.

Client Signature_____ Date_____ _____
Witness Signature (if under 18 years of age)