THE UNIVERSITY OF TEXAS AT AUSTIN
COUNSELING AND MENTAL HEALTH CENTER

100 West Dean Keeton Street STOP A3500 • Austin, Texas 78712-1099 • 512-471-3515 • cmhc.utexas.edu

AUTHORIZATION TO RECEIVE OR TO RELEASE INFORMATION

Please be advised that your mental health records constitute privileged information that is protected by the laws of the State of Texas and that they may contain information that is protected under Federal Confidentiality Regulations. These records cannot be disclosed without your written consent unless otherwise provided for in the federal regulations. Authorizing the release of information contained in your mental health records constitutes waiver of a privilege. You may revoke this consent through written notice, but it will not apply to action that has been taken prior to receipt of the revocation. If not revoked earlier or noted below, this consent form remains in effect while you are enrolled at UT and under the care of CMHC providers.

I, ____

(PLEASE PRINT) LAST NAME   FIRST NAME   MIDDLE INITIAL

request and authorize:

The University of Texas at Austin
Counseling and Mental Health Center
100 West Dean Keeton Street STOP A3500
Austin, Texas 78712-1099

Phone: 512-471-3515
Fax: 512-232-7314

❑ Release to / from   ❑ Discuss with   ❑ Fax to:

NAME ____________________   PHONE ____________________

STREET ADDRESS ____________________   FAX ____________________

CITY ____________________   STATE ____________   ZIP ________

the following information from the record of my care and treatment (please check each category that applies):

- ❑ Counseling and/or psychiatric record
- ❑ Laboratory/assessment instrument
- ❑ Life history questionnaire
- ❑ Client status/intake information
- ❑ Dates of appointments
- ❑ Other, as specified below
- ❑ Conversations as needed to facilitate continuity of care

Other: ____

The disclosure as authorized herein is made for the following purpose:____________________
Please note that the law prohibits further dissemination or use of these records for other purposes.

I specifically authorize the release of information pertaining to drug and alcohol abuse and/or HIV testing/test results if such is a part of the record. Release or transfer of the specified information to any person or entity not specified herein is prohibited by law.

CLIENT SIGNATURE ____________________

On this, the ______ day of ___________, 20____, I have read or have had read to me, the terms and conditions of this agreement and fully understand same. I do freely, voluntarily, and without coercion agree to those terms and conditions contained herein.

SIGNATURE OF WITNESS ____________________   SIGNATURE OF CLIENT ____________________

UT EID ____________________

DATE OF BIRTH ____________________

PHONE ____________________