TUFTS UNIVERSITY COUNSELING AND MENTAL HEALTH SERVICE

PERMISSION TO RELEASE COUNSELING AND MENTAL HEALTH SERVICE INFORMATION

Name (Print) _____
Last First Middle Initial

Tufts ID# _____ **DOB** _____ **Yr. Entered** _____**Yr. Grad**._____

Phone _____**E-mail Address**_____

I understand that I may refuse to sign this form. I understand that I am giving my permission to Tufts University Counseling and Mental Health Service (CMHS) to disclose information from my confidential health care records. I understand that I have the right to revoke my authorization in writing by contacting Tufts University CMHS, except to the extent that Tufts University CMHS has taken action in reliance on this authorization. I also understand that if the person or entity that receives my medical information is not required to comply with the federal privacy regulations, the information described below may be re-disclosed and would no longer be protected by these regulations. I hereby authorize the use and/or disclosure of my counseling/medical information as follows:

I authorize Tufts University Counseling and Mental Health Service to:

- ☐ Release to
- ☐ Obtain from
- ☐ Exchange with

Name of provider(s) or facility and contact information below:

_____

_____

_____

The following information pertaining to myself:

- ☐ Treatment Summary
- ☐ Assessment/Diagnosis
- ☐ History/Intake
- ☐ Dates of treatment/attendance
- ☐ Other (specify)_____

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information. This release expires in 12 months, unless another date is specified here_____.

Signature: _____ ***Date***_____

Witness :_____***Date***_____

Please send requested records to:
Tufts University Counseling and Mental Health Service
120 Curtis Street, Medford, MA 02155
Phone (617) 627-3360 FAX (617) 627-3019

Attention: _____

jr: 2011