

**University Counseling and Testing Center (UCTC)**  
300 Alumni Circle, Mobile, AL 36688/(Telephone) 251-460-7051/(Fax) 251-460-7492

**Authorization for Release of Protected Health Information (PHI)**

NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE NO. (\_\_\_\_) \_\_\_\_\_ J NUMBER \_\_\_\_\_

I hereby authorize the UCTC or any of its staff to use, disclose, or obtain by any acceptable means, including fax, phone, or email my Protected Health Information.

Check the one that applies:    Use PHI      Disclose PHI      Obtain PHI

Dates of records to be released: \_\_\_\_\_

PHI to be used, disclosed, or obtained:

Student Disability Services Dean of Students Office	Treatment Provider ( <i>fill in information below</i> ) Parents/Other Family ( <i>fill in information below</i> ) OTHER _____
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RECIPIENT'S NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

The purpose of this use, disclosure or obtainment is:

At the request of the client Coordination/Continuity of Care	Letter of Support OTHER _____
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\_\_\_\_\_  
Signature of Client or Client's Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client's Representative (if applicable)

\_\_\_\_\_  
Representative's Relationship to Client