AUBURN UNIVERSITY
PSYCHOLOGICAL SERVICES CENTER

Client Authorization to Obtain/Release Information

Client Name _____ Date of Birth _____

I authorize my AUPSC clinician, and/or its administrative and clinical staff to obtain / release the following information (check all applicable boxes):

- ☐ Release psychological treatment records
- ☐ Release psychological testing records
- ☐ Release information from AUPSC
- ☐ Obtain information to AUPSC
- ☐ Obtain medical / psychiatric treatment records
- ☐ Obtain medical / psychiatric testing records
- ☐ Obtain psychological testing / treatment records
- ☐ Obtain educational testing / assessment records
- ☐ Other: _____

This information should be obtained from / released to:

Name _____

Address _____

_____

Phone _____

I am requesting Auburn University Psychological Services Center to obtain/ release this information for:

- ☐ Purposes of psychological assessment and/or treatment
- ☐ At the request of the individual
- ☐ Other: _____

This authorization shall remain in effect until_____ (date)
or until _____(event)

By signing below, I agree to the following conditions:

- I have the right to revoke this authorization at any time by sending a written request to Auburn University Psychological Services Center. However, my revocation will not be effective to the extent that Auburn University Psychological Services Center may have already taken action in reliance on the authorization.
- Auburn University Psychological Services Center may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the Privacy Notice.

_____ _____
Signature of Patient or Authorized Agent of Patient Care Date

_____
Relationship of Above to Patient (e.g., self, parent, legal guardian)

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