CONSENT TO DISCLOSE
PERSONALLY IDENTIFIABLE INFORMATION IN STUDENT HEALTH RECORDS
(Revised November 2026)

Name of Student: _____**Student ID #:** _____ **Date of Birth:** _____

Emory University [via the offices listed below] is authorized to disclose student health records containing identifiable student health information of the above-named individual to the Emory University offices and other entities indicated below. The privacy of such records is protected by the federal Family Educational Right and Privacy Act (FERPA). Please check the boxes in the chart below to indicate the entities with which information may be disclosed and indicate the specific information to be disclosed. You may also provide specific names of those who will coordinate services for you.

Purpose(s) of disclosure(s): _____coordination of care _____case management _____consultation

I hereby authorize the following Emory University Office(s) or outside provider(s) to share records containing medical information including those related to mental health: (*check all that apply*)	**Recipient Office (*check all that apply)***
☐ Counseling & Psychological Services (CAPS) ☐ Student Health Services, Primary Care ☐ Student Health Services, Psychiatry ☐ Student Health Services, Nutritionist ☐ Student Case Management & Intervention Services (SCMIS) ☐ Office of Respect (OOR) ☐ Office for Undergraduate Education (OUE) ☐ Department of Accessibility Services (DAS) ☐ Office of Community Standards and Education ☐ Academic Affairs for the following school_____ ☐ Emory University Psychological Center ☐ Emory Autism Center ☐ Emory University Sports Medicine Staff ☐ International Student and Scholar Services (ISSS) ☐ Oxford Offices all (or specific below): ☐ Center for Counseling and Wellbeing (Oxford College) ☐ Student Health Services (Oxford College) ☐ Coordinator of Student Support (Oxford College) ☐ Advising Support Center (Oxford College) ☐ Parent(s): ☐ Other: add names of additional providers below *Name of Provider/Contact:*	☐ Counseling & Psychological Services (CAPS) ☐ Student Health Services, Primary Care ☐ Student Health Services, Psychiatry ☐ Student Health Services, Nutritionist ☐ Student Case Management & Intervention Services (SCMIS) ☐ Office of Respect (OOR) ☐ Office of Undergraduate Education (OUE) ☐ Department of Accessibility Services (DAS) ☐ Emory University Psychological Center ☐ Emory Autism Center ☐ Emory University Sports Medicine Staff ☐ International Student and Scholar Services (ISSS) ☐ Eating Disorder Treatment Team ☐ Emory Care Team (Associate Deans of Students in Campus Life, Student Case Management and Intervention Services, Emory Police, Counseling and Psychological Services, Student Health Services, Student Health Services Psychiatry, Office of Community Standards and Education, Office of Residence and Sorority and Fraternity Life, Associate Deans of the designated school, Department of Accessibility Services). ☐ Oxford Offices all (or specify below): ☐ Center for Counseling and Wellbeing (Oxford College) ☐ Student Health Services (Oxford College) ☐ Coordinator of Student Support (Oxford College) ☐ Advising Support Center (Oxford College) ☐ Academic Dean for you school (list school) _____ ☐ Parent(s): ☐ Other: ☐ Outside Provider *Name of Provider/Contact:*
Furthermore, I consent to reciprocal release by the specific indicated offices any information back to the Agency/Provider named and amongst all named offices above in order to facilitate indicated purpose(s): **Yes____ No_____**	

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I hereby authorize the selected Emory University Office(s) or outside entities to share records containing the following information (*check all that apply*):

- ☐ Appointment verification
- ☐ Summary of treatment, including progress and recommendations
- ☐ Concerns regarding student's wellbeing
- ☐ Other:

COMMENTS:

If the health information that I have provided consent to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), immunodeficiency syndrome related complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Emory University, its facilities, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

I understand that I may refuse to sign this consent, and that such refusal will in no way affect my ability to receive treatment, payment for treatment or my eligibility to receive health plan benefits. I understand that I can withdraw this consent for release of information at any time prior to this expiration date, except to the extent that action has been taken in reliance hereon. Should I wish to revoke consent for the release of information, or if I disagree with a refusal to release records, I should do so in writing and provide it to the relevant Emory University office(s) that have consent to provide information under this form.

I understand that this consent is valid until (DATE) _____. If I fail to specify an expiration date, this authorization will be valid for one (1) year from the date of my signature.

COMMENTS:

_____ _____

Signature of Student Date

_____ _____

Signature of Legal Representative* Representative's Relationship to Student

*To be used in special circumstances which necessitate signature other than the student's signature. When the student is under the age of 18, this signature *and* the student's signature are required.

EMORY UNIVERSITY REPRESENTATIVE*:*
Please contact the office(s) from which you are requesting Personally Identifiable information to notify them of this and fax them this completed form. You may also give a copy to the student to provide to the recipient directly.

CONTACT INFORMATION		
OFFICE	**PHONE**	**FAX**
Counseling & Psychological Services (CAPS)	*404-727-7450*	*404-727-2906*
Counseling & Career Services (Oxford College)	*404-784-8394*	*770-784-8473*
Student Health Services, Primary Care	*404-727-7551*	*404-727-5349*
Student Health Services, Psychiatry/AOD	*404-727-6145*	*404-712-9086*
Student Health Services, Nutritionist	*404-727-1735*	*404-727-5349*
Student Health Services (Oxford College)	*404-784-8376*	*770-784-8473*
Student Case Management & Intervention Services	*404-727-4693*	*No Fax #*
Coordinator of Student Support (Oxford College)	770-784-8482	*No Fax #*
Office of Respect	*404-727-1514*	*No Fax #*
Office of Undergraduate Education	*404-727-6069*	*404-727-0638*
Department of Accessibility Services	*404-727-9877*	*404-727-1126*
Advising Support Center (Oxford College)	*770-784-4631*	*770-784-4777*
Emory University Psychological Center	*404-727-7451*	*404-727-1284*
Emory Autism Center	*404-727-8350*	*404-727-3969*
Emory University Sports Medicine Staff	*404-727-5613*	*No Fax #*
International Student and Scholar Services (ISSS)	*404-727-3300*	*404-727-0830*