Sol Mental Health RELEASE OF INFORMATION TO University of Texas at Arlington IN THE EVENT OF A MENTAL HEALTH EMERGENCY

A mental health emergency is a situation in which a person's mental health symptoms are so severe that they are unable to function or are at risk of harming themselves or others.

I Authorize Sol Mental Health to Use or Disclose Protected Health Information as outlined below (including mental health information and alcohol/drug treatment and prevention information)

RELEASE INFORMATION TO:

Name/Title: Roy Rudewick

Organization: University of Texas Arlington

Address: 1307 W. Mitchell, Arlington, TX 76013

Phone #: 817-272-2265

Fax # 817-272-5037

EMERGENCY PROTOCOLS

I authorize my clinician to contact me at the phone number I provided in my new patient paperwork and the location I provided in my new patient paperwork in case of an emergency.

EXPIRATION: This authorization will continue indefinitely so long as the individual remains a student-athlete at University of Texas at Arlington or if the individual decides to revoke authorization.

INFORMATION TO BE DISCLOSED: **In an emergency**, I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of my clinical records. This includes specific permission to release all records and other information regarding my treatment, hospitalization, and outpatient care, as is clinically necessary, including: Drug abuse, alcoholism or other substance abuse; Records which may indicate the presence of a communicable or non-communicable disease, and tests for records of HIV/AIDS.

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice to the organization that was authorized to release this information. I understand that revocation of this authorization may affect my ability to receive reimbursement for any medical services from University of Texas at Arlington if such arrangement exists between the

organization that was authorized to release this information and University of Texas at Arlington.

SIGNATURE OF PERSONAL REPRESENTATIVE:

I understand that, by affirmatively checking the box on this inquiry form, I am authorizing the use and/or disclosure of the protected health information identified above.

[ ] By checking this box, if I am above the age of 18, I authorize the release of my clinical records in an emergent mental health emergency to my parents or legal guardian.

SIGNATURE OF LEGAL GUARDIAN: If the consumer/client is under eighteen (18) years old, this authorization must also be signed by a parent/guardian. In the event of an emergency, the parent/guardian listed here will also be notified (if signed below).

Full Name (Print) _____ DOB _____ Phone #_____

Address: _____

Signature of Minor _____ Date _____