



## Student Referral Form

Please complete this form in its entirety with the student. No sections should be left blank.

Student Name: \_\_\_\_\_

Student PSU ID: \_\_\_\_\_

Student PSU Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Student Phone Number: \_\_\_\_\_

Referring Personnel Name: \_\_\_\_\_

Referring Personnel Email: \_\_\_\_\_

Referring Personnel Phone Number: \_\_\_\_\_

May the Counseling Center contact the referring personnel for a referral follow-up?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe the nature of the student's presenting concern: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*If the student's presenting concerns include suicidal thoughts, homicidal thoughts, self-harm, being recently assaulted/raped, or are exhibiting serious physical symptoms of an eating disorder, please call the Counseling Center with the student IMMEDIATELY and request an urgent appointment at 814-898-6504. If the Counseling Center is closed, please call the Penn State Crisis Line with the student IMMEDIATELY for urgent support 24/7 at 877-229-6400.

# Authorization To Disclose Protected Health Information

To be completed by student granting authorization

Penn State Behrend Student Affairs  
Counseling Center  
Penn State Behrend  
212 Erie Hall  
4651 College Dr.  
Erie, PA 16563-0904  
814-898-6504  
Fax: 814-898-6565

Please add the name(s) of the personnel whom the student would like to be included in this authorization:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

I authorize the personnel indicated above and the Counseling Center to release/obtain the following records/information concerning my mental and/or medical health evaluation/treatment for the purpose of coordinating care at Penn State Behrend:

\_\_\_\_\_ Appointment scheduling and attendance

I understand that:

- This authorization is voluntary.
- Treatment at the Counseling Center is not conditional on my signing this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by HIPPA Privacy Rule.
- This authorization will last for a maximum of one year after the date of this authorization.
- I have the right to revoke this authorization at any time by written request. However, revocation will only apply to future disclosures and is not retroactive.

Student Signature: \_\_\_\_\_

Student Printed Full Name (First, Middle, Last): \_\_\_\_\_

Today's Date: \_\_\_\_\_