HUMBOLDT STATE UNIVERSITY
COUNSELING & PSYCHOLOGICAL SERVICES

AUTHORIZATION FOR THE RELEASE OF CLIENT INFORMATION

Client Name ______________________ HSU ID# __________ Date of Birth __________

Email ______________________ Cell/Work# __________ Home Phone __________

Address ______________________ City/State/Zip ______________________

I hereby authorize the verbal and/or written disclosure of the information specified below BETWEEN the following service providers:

Psychotherapist's Name: ______________________

Agency: Counseling and Psychological Services, Humboldt State University, 1 Harpst St, Arcata, CA 95521-8299. **Phone: 707-826-3236 Fax: 707-826-5735 AND**

Name of person/agency ______________________ Phone __________

Fax __________ Address ______________________ City/State/Zip __________

This protected mental health information is being disclosed for the purpose of:

- ❑ Coordination of Psychological Support/Treatment
- ❑ Facilitation of Medical Support/Treatment
- ❑ Support of Academic Withdrawal
- ❑ Transfer of Psychological Treatment
- ❑ Verification of Attendance at CAPS
- ❑ Academic or Housing Issues, specify: __________

❑ Other ______________________

Information to be disclosed:

- ❑ All written treatment records, meaning every page in my record, including but not limited to: paperwork that I completed (Initial forms,), case notes, consultation notes, test results, correspondence, records received from other medical and/or mental health providers.
- ❑ Summary of treatment
- ❑ Treatment recommendations
- ❑ Contact dates (without session content)
- ❑ Verbal consultation

❑ Other ______________________

❑ Restrictions: Authorization is limited to ❑ dates: ______________

❑ services: ______________

This authorization is effective immediately. I understand that I may revoke this authorization in writing at any time, except to the extent information has been released (prior to the revocation) in reliance upon this authorization.

PLEASE NOTE: In authorizing the release of therapy information, you should be mindful of the possibility that your record may contain information such as mental health care, substance abuse and treatment records, HIV/AIDS, or other confidential information that you deem sensitive. If you are unsure of the contents of your counseling record, you should make a request to discuss it with a therapist prior to authorizing release.

Any facsimile, copy or photocopy of the authorization shall authorize the above named individual(s) or agencies to release the records requested herein. This authorization shall be in force and effect **until two years** from the date of execution at which time this authorization expires.

Client/or Other Authorizing Signature ______________________ Date__________

If signature is other than the client, check as applicable: ❑ Parent of a minor
❑ Legal Guardian

(Distribution: Scan, send original to client or person/agency)

4/13