HUMBOLDT STATE UNIVERSITY, COUNSELING & PSYCHOLOGICAL SERVICES

REQUEST & AUTHORIZATION FOR THE RELEASE OF INFORMATION at HSU

Client Name _____ HSU ID# _____

Date of Birth _____ Email _____ Phone _____

Address _____

I hereby authorize the disclosure of information as specified below **BETWEEN** the following **HUMBOLDT STATE UNIVERSITY** offices located at 1 Harpst Street, Arcata, CA.

Counseling and Psychological Services (CAPS), Phone: 707-826-3236, Fax: 707-826-5735 **AND**

- ❑ Dean of Students Office, including CARE Coordinator, Phone: 707-826-3504, Fax: 707-826-5207
- ❑ Educational Opportunity Program, Phone: 707-826-4781, Fax: 707-826-4780
- ❑ Housing and Residence Life, Phone: 707-826-3451, Fax: 707-826-5316
- ❑ HSU Professor/s (list name/s & contact information): _____
  _____
- ❑ Registrar's Office, Phone: 707-826-4101, Fax: 707-826-6194
- ❑ Student Disability Resource Center, Phone: 707-826-4678, Fax: 707-826-5397
- ❑ Student Financial Aid Office, Phone: 707-826-4321, Fax: 707-826-5360
- ❑ Other (list name & contact information): _____

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

- ❑ Facilitation of Psychological Support
- ❑ Verification of Attendance at CAPS
- ❑ Support of Academic Withdrawal
- ❑ Support of Academic Leave
- ❑ Facilitation of Academic Support
- ❑ Facilitation of Financial Aid Support
- ❑ Facilitation of Housing Related Support
- ❑ Support of Basic Needs
- ❑ Other _____

Information to be disclosed:

- ❑ Contact Dates / Services Received
- ❑ Summary of Treatment
- ❑ Other Recommendations
- ❑ Diagnostic Information
- ❑ Health and Safety Concerns & Recommendations
- ❑ Other _____

Authorization is limited to (leave blank if no restrictions):

- ❑ Verbal Consultation
- ❑ Written Records / Letter
- ❑ CAPS service dates: _____
- ❑ CAPS services: _____

This authorization is effective immediately. I understand that I may revoke this authorization in writing at any time, except to the extent information was 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