HUMBOLDT STATE UNIVERSITY
COUNSELING & PSYCHOLOGICAL SERVICES

REQUEST & AUTHORIZATION FOR THE RELEASE OF CLIENT INFORMATION

Client Name _____ HSU ID# _____

Date of Birth _____ Email _____ Phone _____

Address _____

I hereby authorize the verbal and/or written disclosure of information as specified below BETWEEN **Counseling and Psychological Services (CAPS)** at Humboldt State University, 1 Harpst St, Arcata, CA 95521-8299 and the following person/agency/provider.

Name of person/agency _____ Phone _____

Fax _____ Address _____

Purpose of disclosure:

- ❑ Coordination of Psychological Treatment
- ❑ Facilitation / Support of Medical Treatment
- ❑ Consultation
- ❑ Other: _____
- ❑ Transfer of Psychological Treatment
- ❑ Verification of services received at CAPS
- ❑ Provide recommendations

Information to be disclosed:

- ❑ All written treatment records
- ❑ Letter of support
- ❑ Summary of treatment
- ❑ Other: _____
- ❑ Diagnostic impressions
- ❑ Recommendations for care
- ❑ Dates of service

Information being requested:

- ❑ All written treatment records
- ❑ Summary of treatment
- ❑ Other: _____

Permissible methods of information delivery:

- ❑ Verbal exchange
- ❑ Mailing of written records / letter
- ❑ Other _____
- ❑ Fax of written records / letter
- ❑ Client pick up of written records / letter

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

- ❑ 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