UNIVERSITY OF CALIFORNIA, SAN DIEGO
9500 Gilman Drive La Jolla, CA 92093

COUNSELING & PSYCHOLOGICAL SERVICES(MC 0304)
Ph: (858) 534-3755/fax 534-2628

AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

I, ____ Student ID: ________________
(Student's Name/Legal Representative)

Hereby authorize UCSD Counseling & Psychological Services (CAPS) to:

☐ Release information to: ☐ Obtain information from: ☐ Exchange information with:

Name:____
College/Dept/Agency:____
Address:____
Telephone: _________________________ Fax: ______________________________

SPECIFIC INFORMATION TO BE RELEASED. Check each category that applies:

☐ Medical Care, including laboratory and x-ray results
☐ Billing Records
☐ Information Specific to HIV Status
☐ Drug/Alcohol/Substance Abuse Diagnosis/Treatment
☐ Other As Specified _________________________

Mental Health Treatment:

☐ Dates of Treatment
☐ Oral Communication as needed
☐ CAPS Documentation Form
☐ Treatment Summary
☐ Counseling/Psychological Records
☐ Psychiatric Medication Records

For the following purpose(s):

☐ Coordination of treatment/care
☐ Administrative and/or Academic Coordination
☐ Other_________________________________

NOTICE: UCSD Counseling & Psychological Services (CAPS), and other health care providers and organizations such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) This revocation must be delivered in writing to each of the treatment providers listed above.

THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM DATE OF YOUR SIGNATURE

______________________________________ ______________________________

(Student's Signature or Legal Representative) Date