Counseling and Psychological Services

University of Central Florida
Counseling & Psychological Services (CAPS)
4090 Libra Drive
Orlando, FL, 32816-3170
Ph: (407)823-2811 Fax: (407)823-5415

Name:_____

Date: _____

BILLING FORM

TO: BAYCARE

Date of Birth: _____

Phone number: _____

Address: _____

_____

Student Status:

- □ Full time
- □ Part time

This is to verify that the above named student has attended:

□ an initial assessment on_____at _____(Invoice#_____)
date time

□ a counseling appointment on_____at _____(Invoice(s)#_____)
date time

Provider ID#: 4072353599

Authorization to Release Confidential Information

I,_____, hereby authorize the UCF Counseling & Psychological Services (CAPS) to release this form to myself and the above named entity to document services that I have received.

I understand that after this form is released, CAPS cannot guarantee the confidentiality of this document. 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 CAPS staff listed above. This consent will automatically expire one year from the date of client's signature.

_____
Signature of Client Date

_____
Signature of Parent/Legal Guardian (if applicable) Date