Counseling and Psychological Services

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

In order to protect your right to confidentiality, your written authorization is required if you request information to be released to another person or agency. Counseling and Psychological Services (CAPS) records are kept separate from your educational records for confidentiality purposes. However, information released to faculty and staff, for petitions, for recommendation for referrals or other such released information becomes the property of the recipient, and at the time, the Counseling and Psychological Services (CAPS) cannot guarantee the confidentiality of those documents.

I _____ authorize _____ and other appropriate clinical staff members of CAPS to:

☐ release to ☐ obtain from ☐ exchange with the following:

Client's initial

_____ ☐ UCF Student Health Services

PATIENT AUTHORIZATION TO RELEASE INFORMATION AND CONSENT TO DISCUSS FOR STUDENT HEALTH SERVICES

I approve the release of the information below and authorize UCF Student Health Services to retrieve and share information from appointments resulting from this referral. I hereby authorize you to discuss and/or disclose the specific information described below, only for the purposes of appointments resulting from this referral and for parties also described. **If for any reason I decide to revoke this authorization or consent, it is my responsibility to inform my Student Health Services provider**.

To facilitate communication between UCF CAPS and UCF Student Health Services, the following additional information is requested:

_____ _____

Signature of Client Date

_____ ☐ Other _____

the following information pertaining to myself:

Client's initial

_____ ☐ attendance

_____ ☐ treatment progress

_____ ☐ treatment summary

_____ ☐ medical record (abstract, psychiatry, discharge paperwork)evaluation/

_____ ☐ other _____

for the purpose of: ☐ evaluation/assessment and/or coordinating treatment efforts other

☐ (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below.
I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time by giving written notice (except to the extent that the information has already been released).

Signature of Client PID Date Date of Birth Age Phone Number

Staff Member Name (Print) Staff Member Signature Date

For any student who is under 18 years of age, a parent/guardian signature is required.

Parent/Guardian Printed Name Parent/Guardian Signature Date