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_____

PID _____

Date of Birth _____

Phone Number _____

RECORD REQUEST FORM

Date: _____

Authorization to Release Confidential Information

I, _____, hereby authorize UCF Counseling & Psychological Services (CAPS) to release my counseling record and/or treatment summary to (SELF or specific name of individual):_____

Check below how the above person will receive the records requested.

☐ Mail

Address:_____

☐ Fax

Fax Number:_____

☐ Encrypted Email

Email Address:_____

Initials:

_____additionally, I hereby authorize UCF Counseling & Psychological Services (CAPS) to communicate with above entity regarding my counseling records.

The reason for this request is (please mark X or check mark):

☐ Send records to another treatment provider

☐ SAP appeal

☐ Faculty/professor communication

☐ Legal Reasons

☐ Other:_____

☐ Medical Withdrawal Petition

☐ Student Accessibility Services (SAS)

☐ Job application or background check

☐ Letter of support

I understand that after my counseling record is released, CAPS cannot guarantee the confidentiality of any information contained in it. If a printed copy of my complete record is requested, I acknowledge that there is a fee (a) For the first 25 pages, the cost shall be $1.00 per page. (b) For each page in excess of 25 pages, the cost shall be 25 cents, which is due prior to the transmission of my record to the desired recipient. A copy of this form is as valid as the original.

_____

Signature of Client Date

_____

Signature of Parent/Legal Guardian if client is under 18 years old Date

This release is only valid for one year per date of form