CALIFORNIA STATE UNIVERSITY
FULLERTON
STUDENT WELLNESS

Counseling and Psychological Services
800 N. State College Blvd., Fullerton, CA 92831-6830
T: 657-278-3040 | F: 657-278-2971

ATTENDANCE VERIFICATION FORM

I ________________________________ CWID #: __________________ DOB: ___________
print name

authorize Counseling and Psychological Services (CAPS) of California State University, Fullerton to release the dates I was seen in CAPS, the names of the providers with whom I met, and the provider's assessment of the severity of my impairment in daily functioning to:

Office /Agency: ______________________________________ Attn: ____________________
Address: ____
Phone: ____ Fax: _____________________

I understand that the purpose of this release or exchange of information is to provide information for academic or administrative considerations. I understand that this consent will automatically expire one (1) year from the date of my signature as it appears below, or on the following earlier date:________________________.

I understand that I have the right to refuse to sign this form, obtain a copy of this authorization, and revoke my consent at any time (except to the extent that the information has already been released). Revocation of consent must be delivered in writing.

___________________________________ ___________________________________
Client Signature Date Witness Signature Date

Please be advised that the student named above has received mental health services at Counseling and Psychological Services (CAPS). The student was seen at CAPS on the following date(s) by the provider(s) indicated:

Dates: ______________________________ Provider: ____________________________

Dates: ______________________________ Provider: ____________________________

Please consider the following information when making decisions impacting this student:

☐ Yes ☐ No The student currently meets full diagnostic criteria for a mental disorder that has severely impacted his or her daily functioning.

☐ Yes ☐ No The student experienced a recent traumatic event that has severely impacted his or her daily functioning.

___________________________________ ___________________________________
Counselor Signature Supervisor Signature (if applicable)

REVISED 6/30/2017