CALIFORNIA STATE UNIVERSITY, FULLERTON

Division of Student Affairs
Student Wellness / Counseling and Psychological Services
800 N. State College Blvd., Fullerton, CA 92831-6830 / T 657-278-3040 / F 657-278-2971

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ authorize Counseling and Psychological Services (CAPS) of California State University, Fullerton (CSUF) to **release** information to, **obtain** information from, **disclose** information to and/or **exchange** information with:

Name/Agency/Department: _____

Phone: _____ Fax: _____

Address:_____
(street) (city) (state) (zip)

Regarding (Client Name) : _____

Phone: _____

DOB: _____ CSUF CWID #:_____

Authorizing Provider: _____AND/OR CSUF CAPS

I authorize the following information to be released:

- ☐ A letter to include the following: _____
- ☐ Confirmation of dates of attendance
- ☐ Entire Mental Health Record
- ☐ Psychiatry Records
- ☐ Diagnosis and treatment progress
- ☐ Results of assessments and recommendations
- ☐ Other (specify): _____

I understand that the purpose of the release or exchange of information is:

- ☐ Academic or administrative considerations
- ☐ Continuing Care/Further Treatment
- ☐ Treatment Planning/Coordination
- ☐ Personal review
- ☐ Legal review
- ☐ Other: _____

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. If you revoke this authorization it will not have any effect on actions taken by CAPS in reliance on this authorization prior to receiving the revocation. It is expressly understood that photocopies of this authorization shall be as valid as the original.

By signing below, I acknowledge that I am authorizing and consenting to the release of my health records. This consent will automatically expire one (1) year from the date of my signature as it appears below, or on the following earlier date: _____.

Client Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

This information has been disclosed to you from the Counseling and Psychological Services health files of California State University, Fullerton. The intentional redisclosure of this information may subject you to a civil action under Section 1793.53 of the Civil Code for invasion of privacy by the individual(s) to whom the information pertains. You are advised to be certain of your authority to further disclose any of this information before doing so.