Caltech

STUDENT COUNSELING SERVICES
1239 Arden Rd., Mail Code 1-8, Pasadena, CA, 91125
626-395-8331 - Phone 626-585-1522 - Fax

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION/RECORDS BY STUDENT COUNSELING SERVICES

Student Name: _____

Date of Birth: _____ Year Graduated: _____

Address: _____

Phone Number: _____ Email Address: _____

I, the undersigned, hereby authorize and consent to the disclosure of the specific information listed in this document.

DISCLOSURE BETWEEN	
Caltech Student Counseling Services 1239 Arden Road Pasadena, CA 91125	*(Name and address of organization and/or person to which disclosure is to be made)*
Phone: (626) 395-8331 Fax: (626) 585-1522	Phone: Fax:

Purpose: I authorize the release of the specific information for the following purpose(s) *(if more space is needed use the back of the form)*: _____

_____

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, except as limited below.
- ☐ Only the following records or types of health information:

  _____

Alcohol/Drug Abuse and Mental Health Treatment: I understand that this Authorization may include disclosures of information relating to alcohol and drug abuse and mental health treatment (except psychotherapy notes) only if I place my initials on the appropriate line below. If I am authorizing the release of alcohol or drug treatment or mental health information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

Alcohol/drug treatment information _____

Mental health treatment information _____

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until _____, 20____.
- ☐ Until the Provider fulfills this request.

I understand that:

1. I can revoke this Authorization at any time by giving my written revocation to the Disclosing Provider.
2. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
3. The disclosing provider may not condition treatment on whether I sign this Authorization.
4. I am authorizing disclosure of information protected under federal or state law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
5. A photocopy or facsimile of this authorization shall be valid as the original authorization.
6. This Authorization will remain in effect during the term indicated above or until otherwise revoked by the undersigned client.
7. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Client Today's Date

Records Release Office Use Only:

Authorized by: _____ Released on: _____