Santa Clara UNIVERSITY

500 El Camino Real Bldg. 701
Santa Clara, CA 95053
Phone: (408) 554-4501
Fax: (408) 554-5454

PERMISSION FOR RELEASE OF INFORMATION

Student Health Counseling and Well-Being: Counseling and Psychological Services (CAPS)

Completing this form authorizes Student Health, Counseling, and Well-Being at Santa Clara University to release information and/or health care records to the person/agency indicated below.

Client/Patient Information [Print Below]

_____

Name | Date of Birth | Student ID

_____

Address | City | State/Zip | Daytime Phone

Type of Release

- ☐ **Verbal/Written Disclosure**
- ☐ **Release of Mental Health Record(s)**

Permission to Disclose Information or Release Mental Health Record(s)

- ☐ **Disclose Information to Person/Agency Below**
- ☐ **Exchange Information with Person/Agency Below**
- ☐ **Receive Information from Person/Agency Below**

Disclose Information/Records to: [Print Below]

Name of Person/Agency: _____

Address: _____

Phone Number: _____ Fax: _____ Email: _____

Information to be Disclosed/Released

I consent to the release/disclosure of (Check all appropriate boxes):

- ☐ **Intake and Discharge Summaries**
- ☐ **Attendance Information**
- ☐ **Verification of Treatment**
- ☐ **Records pertinent only to my appointments on or about (date):**

  _____
- ☐ **Psychological Testing Records**
- ☐ **Records related to Case Management Services**
- ☐ **Information regarding treatment**
- ☐ **Other:**_____

  _____

Santa Clara UNIVERSITY

500 El Camino Real Bldg. 701
Santa Clara, CA 95053
Phone: (408) 554-4501
Fax: (408) 554-5454

Purpose of Disclosure/Release of Information and/or Records

- ☐ **Further Psychological Evaluation and/or Treatment**
- ☐ **Withdrawal/Readmission Process**
- ☐ **Coordination of Services**
- ☐ **Disability Resource Application**
- ☐ **Other: _____**

The following Information <u>will not</u> be released unless you specifically authorize it by marking the relevant box(es) below:

- ☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (42 C.F.R. 2.34 and 2.35).
- ☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code 120980(g)).
- ☐ I specifically authorize the release of genetic testing information (Health and Safety Code 124980(j)).

Confidentiality Notice

Student Health, Counseling, and Well-Being are required to keep your health information confidential by state and federal law. **If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal law.**

Your Rights

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party. This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Student Health Counseling and Well-Being at 500 El Camino, Bldg. 701, Santa Clara, CA, 95053. The revocation will take effect when Student Health, Counseling and Well-Being receives it.

You are entitled to receive a copy of this Authorization. I understand that my eligibility for services at Student Health, Counseling, and Well-Being is not contingent upon my signing this release form.

Expiration of Authorization

Unless otherwise revoked, this Authorization expires _____ (insert applicable date). If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

RE-DISCLOSURE: I understand that any re-disclosure of the above information is prohibited beyond this release and that any such re-disclosures require a new Release of Information Form signed by me.

Printed Name	Client Signature	Date