Counseling and Psychological Services, Bldg. 599
University of California
Santa Barbara, CA 93106-7030

UNIVERSITY OF CALIFORNIA COUNSELING & PSYCHOLOGICAL SERVICES
Consent to Release/Exchange Information

Your Right to Medical Information Confidentiality: HIPAA is an acronym that stands for Health Insurance Portability and Accountability Act that was made into law in 1996. By law, if you are 18 years of age or older, you have the right to strict confidentiality regarding your visits to Student Health and Counseling Services. In order to release and information including the date or nature of your visit, Student Health and Counseling Services must have your signed consent and specific directions about what information you are consenting to be released. Without written consent, Student Health and Counseling Services cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, faculty, staff, coach and other medical professionals.

Today's Date_____ Name_____ Date of Birth ___/___/___ Perm/ID #_____

I authorize Counseling & Psychological Services to release/exchange health and/or counseling information about me to:

Name_____

Address:_____

City:_____ State_____ Country_____ Zip Code:_____

Phone:_____ Fax: _____

Specific type of information to be released and/or exchanged:

Mental Health treatment
☐ Treatment dates
☐ Oral communication as needed
☐ Psychotropic medication records
Notes: _____

Counseling and Psychological Services (CAPS)
☐ Record
☐ Documentation Form
☐ Treatment Summary
Notes:_____

Specific Alcohol/Drug and HIV releases
☐ Alcohol/drug abuse
☐ HIV-related information

Other Information
☐ Medical care (including laboratory and x-ray results)
☐ Billing records
☐ Other types of information to be released
Notes:_____

Periods of Care: From _____ to _____

I understand that the information is to be used for:
☐ Academic considerations
☐ Coordination of services/continuity of care
☐ Assessment of functioning request for off-campus programs, Peace Corps, or other applications
☐ Other use of released information
Notes:_____

NOTICE: University of California Student Health Services, Counseling & Psychological Services, and other health care providers and organizations such as physicians, hospitals and health plans are required by law to keep your health information confidential. 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 confidentiality laws.

I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign the form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) This revocation must be delivered in writing to each of the treatment providers listed above.

This release expires in one year unless another date is specified:_____
Client signature:_____
Therapist to undersign in the space below: _____