CAL POLY

Counseling Services

Phone: (805) 756-2511 • Fax: (805) 756-6525

AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION

Name (Printed): _____ Phone Number: _____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City State Zip Code

Phone: _____ FAX: _____

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City State Zip Code

Phone: _____ FAX: _____

I AUTHORIZE the following information to be disclosed for the following date(s): _____
(Please initial all that apply)

_____ Entire Record _____ Appointment History _____ Attendance _____ Letter
_____ Phone Call _____ Treatment Summary _____Diagnosis _____Recommendations
_____ Only the following information: _____
_____

REASON for disclosure of mental health information: (Please initial one)

_____ At my request _____ Job _____ Academic _____ Insurance
_____ Legal _____Coordination of Care _____ Other (specify): _____
_____

EXPIRATION of this Authorization: ***Per California law, this Authorization will automatically expire 12 months after the date of my signing this form unless you specify an earlier expiration date.*

_____ 90 days after signature date _____ On this date: _____
_____ When this event happens: _____

ADDITIONAL CLIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.*
- I understand that I do not have to sign this authorization to receive/continue receiving treatment.
- I understand that once my mental health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by Cal Poly Counseling Services.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

_____ Date: _____
Student Signature (Parent or Legal Representative, as applicable)

*I wish to withdraw this authorization: _____ Date: _____