UNIVERSITY OF CALIFORNIA, SAN DIEGO
9500 Gilman Drive La Jolla, CA 92093

STUDENT HEALTH SERVICES (MC 0039) Ph: (858)534-2139/fax 534-7545

COUNSELING & PSYCHOLOGICAL SERVICES(MC 0304) Ph: (858) 534-3755/fax 534-2628

AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION

I, _____ Student ID: _____
(Student's Name/Legal Representative)

Hereby authorize UCSD Student Health Service AND Counseling & Psychological Services to:

☐ Release information to: ☐ Obtain information from: ☐ Exchange information with:

Name:_____

College/Dept/Agency:_____

Address:_____

Telephone: _____ Fax: _____

SPECIFIC INFORMATION TO BE RELEASED. Check each category that applies:

___ Medical Care, including laboratory and x-ray results
___ Billing Records
___ Information Specific to HIV Status
___ Drug/Alcohol/Substance Abuse Diagnosis/Treatment
___ Other As Specified _____

Mental Health Treatment:
___ Dates of Treatment
___ Oral Communication as needed
___ CAPS Documentation Form
___ Treatment Summary
___ Counseling/Psychological Records
___ Psychiatric Medication Records

For the following purpose(s):

☐ Coordination of treatment/care
☐ Administrative and/or Academic Coordination
☐ Other_____

NOTICE: UCSD 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 this 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 CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM DATE OF YOUR SIGNATURE

_____
(Student's Signature or Legal Representative) (Date)

_____
(Printed Name)