



# Counseling and Psychological Services

## AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

In order to protect your right to confidentiality, your written authorization is required if you request information to be released to another person or agency. Counseling and Psychological Services (CAPS) records are kept separate from your educational records for confidentiality purposes. However, information released to faculty and staff, for petitions, for recommendation for referrals or other such released information becomes the property of the recipient, and at the time, the Counseling and Psychological Services (CAPS) cannot guarantee the confidentiality of those documents.

I \_\_\_\_\_ authorize \_\_\_\_\_ and other appropriate clinical staff members of CAPS to:

- release to
- obtain from
- exchange with the following:

Client's initial

- \_\_\_\_\_  UCF Student Health Services
- \_\_\_\_\_  Other \_\_\_\_\_

the following information pertaining to myself:

Client's initial

- \_\_\_\_\_  attendance
- \_\_\_\_\_  treatment progress
- \_\_\_\_\_  treatment summary
- \_\_\_\_\_  other \_\_\_\_\_

- for the purpose of:
- evaluation/assessment and/or coordinating treatment efforts
  - other (specify) \_\_\_\_\_

This consent will automatically expire one (1) year after the date of my signature as it appears below. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time by giving written notice (except to the extent that the information has already been released).

Signature of Client	PID	Date	Date of Birth	Age
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Staff Member Name (Print)	Staff Member Signature	Date
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**For any student who is under 18 years of age, a parent/guardian signature is required.**

Parent/Guardian Printed Name	Parent/Guardian Signature	Date
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