UCF | 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

_____ ☐ medical record (abstract, psychiatry, discharge paperwork)

_____ ☐ 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

_____

Staff Member Name (Print) Staff Member Signature Date

For any student who is under 18 years of age, a parent/guardian signature is required.

_____ _____ _____

Parent/Guardian Printed Name Parent/Guardian Signature Date

4090 Libra Dr. Bldg 27 Room 101 Orlando, FL 32816
PH: (407) 823-2811 FAX: (407) 823-5415