UCF | **Counseling and Psychological Services**

University of Central Florida
Counseling & Psychological Services (CAPS)
4090 Libra Drive
Orlando, FL, 32816-3170
Ph: (407)823-2811 Fax: (407)823-5415

Name________________________________

PID ________________________________

Date of Birth _________________________

Phone Number _______________________

RECORD REQUEST FORM

Date: ______________________________

Authorization to Release Confidential Information

I, __________________________________, hereby authorize UCF Counseling & Psychological Service (CAPS) to release my counseling record and/or treatment summary to:

Name:
Address:
Fax:

Initials:
________additionally, I hereby authorize UCF Counseling & Psychological Service (CAPS) to communicate with above entity regarding my counseling records.

The reason for this request is (please mark X or check mark):

___Send records to another treatment provider

___Medical Withdrawal Petition

___SAP appeal

___Student Accessibility Services (SAS)

___Faculty/professor communication

___Job application or background check

___Legal reasons

___Letter of support

___Other:____

I understand that after my counseling record is released, CAPS cannot guarantee the confidentiality of any information contained in it. A copy of this form is as valid as the original.

____

Signature of Client Date

____

Signature of Parent/Legal Guardian if client is under 18 years old Date

This release is only valid for one year per date of form