



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 Services (CAPS) to release my counseling record and/or treatment summary to:

Name:
Address:
Fax:

Initials:

_____ additionally, I hereby authorize UCF Counseling & Psychological Services (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. If a printed copy of my complete record is requested, I acknowledge that there is a fee of 40 cents per page, which is due prior to the transmission of my record to the desired recipient. 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