

Santa Clara University
Counseling and Psychological Services (CAPS)
CONSENT FOR RELEASE OF INFORMATION

RE: _____ BIRTHDATE: ____/____/____
(Client) STUDENT ID _____

I hereby authorize the exchange or release of information between:

(Counselor)

and the following person and/or agency:

(Name/Agency) _____
(Relationship)

(Address) (_____) _____
(Phone)

The following information is to be released to from the Santa Clara University Counseling and Psychological Services:

- Intake and Discharge Summaries
- Psychological Evaluation
- Progress Notes and Treatment
- Other: _____

For the purpose of:

- Further psychological evaluation and/or treatment
- Case management and/or consultation
- Other: _____

I understand that my eligibility for services at CAPS is not contingent upon my signing this release form. Furthermore, I understand that any re-disclosure of the above information is prohibited beyond this release and that any such redisclosures require a new Release of Information Consent signed by me.

This consent will automatically expire at the end of this academic year or by the date below.

Expiration date: _____

I understand 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).

(Signature of Client)

(Date)