CAL MARITIME

COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS)
Student Health Services
200 Maritime Academy Drive | Vallejo, CA 94590
(707) 654-1170 | Fax (707) 654-1171
www.csum.edu/caps

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Name: _____ Date of Birth: _____

Purpose of this disclosure: _____
(Examples: Coordination of Care, Evaluation, Academic Support, Documentation, referral)

I authorize Counseling and Psychological Services (CAPS) to release/exchange information contained in my counseling record between CAPS and:

☐ Cal Maritime Student Health Services medical providers

Name: _____ **Organization/Agency:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone: _____ **Fax:** _____

Information released/requested confined to the following:

Counseling & Psychological Services (CAPS)

☐ Courseload Reduction Information
☐ Psychological & Counseling Evaluations & Progress Notes
☐ Lab Reports/Tests
☐ Verification of Treatment
☐ Financial Aid Appeal Letter Information
☐ Psychiatric Progress Notes, Evaluation & Medication Reports
☐ Psychological Testing Reports
☐ Entire CAPS Record

☐ Other: _____

Information and records requested may contain references to: HIV/AIDS status, substance use disorders, and sexual assault.

HIV/AIDS Status	**Substance Use Disorders**	**Sexual Assault**
☐ **I DO want it included**	☐ **I DO want it included**	☐ **I DO want it included**
☐ **I DO NOT want it included**	☐ **I DO NOT want it included**	☐ **I DO NOT want it included**

This authorization automatically expires in 90 days unless otherwise indicated.

Other Date/Event: _____

This information is intended only for the named recipient herewith. It may not be given to another individual or agency without the patient's consent. This authorization will expire 90 days from the date below. I understand that I may revoke this authorization and **must do so in writing**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, except when such disclosure may be a severe detriment to patient/client welfare. The patient may request to review Counseling and Psychiatric records with their provider as provided by CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the director of CAPS or Student Health Services.

_____ _____
Signature Date

_____ _____
Signature (Parent/Guardian) If Applicable Date