

REQUEST & AUTHORIZATION FOR THE RELEASE OF INFORMATION at HUMBOLDT

Client Name _____ Humboldt ID# _____
Date of Birth _____ Email _____ Phone _____
Address _____

I hereby authorize the disclosure of information as specified below **BETWEEN** the following **CAL POLY HUMBOLDT** offices located at 1 Harpst Street, Arcata, CA.

Counseling and Psychological Services (CAPS), Phone: 707-826-3236, Fax: 707-826-5735 **AND**

- Dean of Students Office, including CARE Coordinator, Phone: 707-826-3504, Fax: 707-826-5697
 - Educational Opportunity Program, Phone: 707-826-4781, Fax: 707-826-4780
 - Housing and Residence Life, Phone: 707-826-3451, Fax: 707-826-5316
 - Humboldt Professor/s (list name/s & contact information): _____
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- Registrar’s Office, Phone: 707-826-4101, Fax: 707-826-6194
 - Student Disability Resource Center, Phone: 707-826-4678, Fax: 707-826-5397
 - Student Financial Aid Office, Phone: 707-826-4321, Fax: 707-826-5360
 - Other (list name & contact information): _____

This protected mental health information is being disclosed for the purpose of:

- | | |
|--|--|
| <input type="checkbox"/> Facilitation of Psychological Support | <input type="checkbox"/> Facilitation of Academic Support |
| <input type="checkbox"/> Verification of Attendance at CAPS | <input type="checkbox"/> Facilitation of Financial Aid Support |
| <input type="checkbox"/> Support of Academic Withdrawal | <input type="checkbox"/> Facilitation of Housing Related Support |
| <input type="checkbox"/> Support of Academic Leave | <input type="checkbox"/> Support of Basic Needs |
| <input type="checkbox"/> Fulfilling the request of the student | <input type="checkbox"/> Other _____ |

Information to be disclosed:

- | | |
|--|---|
| <input type="checkbox"/> Contact Dates / Services Received | <input type="checkbox"/> Diagnostic Information |
| <input type="checkbox"/> Summary of Treatment | <input type="checkbox"/> Health and Safety Concerns & Recommendations |
| <input type="checkbox"/> Other Recommendations | <input type="checkbox"/> Other _____ |

Authorization is limited to (leave blank if no restrictions):

- | | |
|---|--|
| <input type="checkbox"/> Verbal Consultation | <input type="checkbox"/> CAPS service dates: _____ |
| <input type="checkbox"/> Written Summary / Letter | <input type="checkbox"/> CAPS services: _____ |

This authorization is effective immediately. I understand that receipt of CAPS services is not conditional on whether I sign this authorization and that I may revoke this authorization in writing at any time, except to the extent information was released (prior to the revocation) in reliance upon this authorization. I further understand that information, once disclosed by CAPS, may be redisclosed by the recipient, and is no longer protected by health laws and regulations. I understand that I am entitled to a copy of this authorization upon request.

PLEASE NOTE: In authorizing the release of therapy information, you should be mindful of the possibility that your record may contain information such as mental health care, substance abuse and treatment records, HIV/AIDS, or other confidential information that you deem sensitive. If you are unsure of the contents of your counseling record, you should make a request to discuss it with a therapist prior to authorizing release.

Any facsimile or photocopy of this ROI shall authorize CAPS to release the information requested herein. This authorization shall be in force and effect **until 2 years** from the date of execution at which time this ROI expires.

Client/or Other Authorizing Signature _____ Date _____
If signature is other than the client, check as applicable: Parent of a minor Legal Guardian