CAL MARITIME

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

AUTHORIZATION FOR EXCHANGE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client/Patient Name: _____

Cal Maritime ID: _____ Date of Birth: _____

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

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

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

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

HIV/AIDS Status	Substance Use Disorders	Mental Health & 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. 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 his/her 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 Student Health Services.

_____ _____
Signature Date

_____ _____
Signature (Parent/Guardian) If Applicable Date