I hereby authorize the Student Health Center (SHC) Counseling and Psychological Services (CAPS) at Cal State LA and

Counselor Name: _____

to ☐ release and/or ☐ obtain information pertaining to my mental health treatment to and/or from:

Name: _____

Title / Relationship: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax (_____) _____

Information to be released/obtained:

☐ Brief letter regarding: _____

☐ Written treatment summary

☐ Copy of mental health or medical records: _____
(Clearly specify records to be released)

☐ Other: _____

The purpose for which the information may be used is: _____

This authorization is valid until: _____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand my personal health information disclosed under this authorization might be re-disclosed by the recipient, and my disclosed personal health information may no longer be subject to federal or state privacy laws protecting health records.

Patient Information:

Print Name: _____ CIN: _____

Signature: _____ Date: _____

Or Signed by Personal Representative:

_____ Date _____

On Behalf of:

_____
Name of Patient

Forms/CAPSRelease/RequestInfo/011018

STUDENT HEALTH CENTER
5151 State University Drive
Los Angeles, California 90032
(323) 343-3314 Fax (323)343-6557

RELEASE and/or OBTAIN INFORMATION
Counseling and Psychological Services (CAPS)

Last Name _____

First _____

CIN _____