AUTHORIZATION TO RELEASE MENTAL HEALTH INFORMATION/RECORDS

*A printing fee, not to exceed one dollar (\$1) per page will be charged by the CAPS office for furnishing copies of the client's mental health record upon request by the client.

Client Name:	
PeopleSoft ID#:	Date of Birth: (mm-dd-yyyy)
□ I authorize CAPS to release records TO (select all that apply): □ Self (Client listed above) □ Other: Name Address: □ City, State, Zip □ Phone □ Fax □ Mail the records □ I will pick up the records □ Fax the records □ Verbal consultation only	The purpose of this disclosure is FOR: Continuation of care Attendance verification Application for academic accommodations Medical Withdrawal Litigation/Criminal proceedings Application for employment Other (specify):
□ I authorize	to release records to CAPS
Information to be disclosed is limited to: Psychological Report Attendance Records Diagnosis Billing Record Other: (specify)	☐ Treatment Plan ☐ Treatment Summary ☐ Withdrawal / Re-admission recommendation ☐ All Progress Notes ☐ All Treatment Records *by checking this box I indicate that progress notes will be included when records are requested.
signature)	that action has already been taken on it. Specify Expiration of Authorization (from date o
Client (or authorized representative) signat	ture Date