

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

By signing this form, you are authorizing CPS to release otherwise confidential psychological information to one or more people whom you designate. Please read carefully. We will gladly answer any questions.

I authorize Counseling and Psychological Services to: *(Check all that pertain)*

- Discuss** otherwise confidential information pertaining to my treatment
- Transmit a copy of my otherwise **confidential health record**
- Transmit a **letter** or treatment **summary** containing my otherwise confidential information

I authorize the release of the information specified above to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is released for the following purpose(s):

- To facilitate treatment planning
- To provide information relevant to academic accommodations and/or medical leave of absence
- Other: \_\_\_\_\_

If you have authorized us to **discuss** confidential information, specify the period during which we may communicate with the person(s) listed above, by checking the appropriate box below:

- I authorize ongoing communication unless I revoke this consent.
- I authorize communication only until \_\_\_\_\_ (specify date).

***Other restrictions or limitations on information to be released (specify):***

- \_\_\_\_\_
- No other limitations

I understand that I do not have to agree to release confidential information, and that I may withdraw this consent at any time except insofar as action has already been taken in reliance thereupon. A facsimile of this form will be regarded as valid as the original.

**Signature:** \_\_\_\_\_

**Name (printed):** \_\_\_\_\_

**Date:** \_\_\_\_\_

If not personally known to CPS, student's identity was verified by:  CUID  Photo ID (specify type and number) \_\_\_\_\_  Other \_\_\_\_\_

**HIV-Related information**

If you have discussed HIV-related information with your counselor, your CPS records may include this information. You may choose to release only non-HIV medical information, or allow disclosure of HIV-related information as well. Confidential HIV-related information may indicate that a person has had an HIV-related test, or has HIV infection or an HIV-related disease or AIDS, or has been exposed to the HIV virus. (Check **and sign name** beside ONE of the following options):

- I consent to the release of my **full** record, including any confidential HIV-related information it may contain.  
Signature: \_\_\_\_\_
- I **do not** consent to the release of HIV-related information. I understand that if I am otherwise authorizing the release of my complete health record, all HIV-related information will be removed, and the record will be marked as "redacted." If I am authorizing verbal communication and/or the transmission of a letter or summary, HIV-related information will not be included.

Signature: \_\_\_\_\_