I, _____, hereby authorize the Cowell Center at Santa Clara University located at 500 El Camino Real Bldg. 701, Santa Clara, CA 95053; : (408) 554-4501 : (408) 554-5454

☐ **Disclose information to:** ☐ **Receive information from:** ☐ **Exchange information with:**

Name: _____

Address: _____

Phone Number: _____ Fax: _____

Records and information pertaining to:

_____

Client Name | Date of Birth | Student ID

_____

Address | City | State/Zip | Daytime Phone

INFORMATION TO BE DISCLOSED:

☐ Intake and Discharge Summaries
☐ Attendance Information
☐ All Treatment Records
☐ Other (specify): _____
☐ Psychological Evaluation
☐ Withdrawal / Readmission Recommendation

FOR THE PURPOSE OF:

☐ Further psychological evaluation and/or treatment
☐ Withdrawal/Readmission process
☐ Other (specify): _____
☐ Case management and/or consultation

EXPIRATION: This authorization will become effective immediately and shall be in effect until
☐ End of academic year ☐ Date specified: _____

REVOCATION: I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

YOUR RIGHTS: I understand that my eligibility for services at CAPS is not contingent upon my signing this release form.

RE-DISCLOSURE: I understand that any re-disclosure of the above information is prohibited beyond this release and that any such re-disclosures require a new Release of Information Form signed by me.

_____ _____ _____

Print Name | Client Signature | Date