

**Counseling and Psychological Services**  
30 Bee Street, Suite 101  
MSC 980  
Charleston, SC 29425  
Tel 843-792-4930  
Fax 843-792-2535

**Authorization Form  
Release of Information for Required Evaluation  
Counseling and Psychological Services**

This form, when completed and signed by you, authorizes Counseling and Psychological Services (CAPS) to release protected information from your clinical record to the person or persons you designate.

I, \_\_\_\_\_, authorize \_\_\_\_\_ and/or his or her clinical supervisor at CAPS  
(student name) (CAPS provider)

and/ or the Director of CAPS and / or the administrative staff at CAPS to release to:

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

(individual(s) to whom information is being released)

All information obtained related to the completion of the required evaluation, findings of the evaluation, and recommendations related to the reason for referral.

I am requesting the release of this information at the request of the program.

This authorization shall remain in effect until the evaluation has been completed and the findings communicated with the referring individual.

I understand I have the right to revoke this authorization in writing at any time by sending such written notification to the CAPS office. However, the revocation will not be effective to the extent that CAPS has already taken action in reliance on the authorization.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule

\_\_\_\_\_

\_\_\_\_\_

Signature of patient

Date

(If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.)