



Counseling and Psychological Services  
30 Bee Street, Suite 101  
MSC 980  
Charleston, SC 29425  
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## Release of Information Authorization Form

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/agency you designate,

I, \_\_\_\_\_, authorize \_\_\_\_\_ and/or his or her clinical supervisor at CAPS and/or the Director of CAPS and/or the administrative staff at CAPS (cross out if not applicable) to release to and/or receive from:

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The following information:

- All information obtained
- Attendance at therapy
- Diagnoses
- Treatment recommendations
- Adherence to treatment recommendations
- Lab results
- Urine drug screens and other biological markers related to substance use
- Prognosis
- Psychological suitability for continuing in academic program
- Ability to function in class work
- Ability to function in clinics
- Recommendations regarding medical leave of absence
- Letter summarizing my care
- Results of testing and recommendations
- Other \_\_\_\_\_

I am requesting the release of this information for the following reasons:

- At the request of the individual (all that is required if you do not desire to state a specific purpose)
- At the request of the program
- Other \_\_\_\_\_

This authorization shall remain in effect until (fill in expiration date): \_\_\_\_\_

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

I understand that CAPS generally may not make services conditional upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party (For example, if I am required by my Dean or Program Director to receive psychological evaluation.)

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

\_\_\_\_\_  
Signature of Patient

Date

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