Caltech

STUDENT WELLNESS SERVICES
1239 Arden Rd., Mail Code 1-8, Pasadena, CA, 91125
Counseling Services and Occupational Therapy: 626-395-8331
Health Services: 626-395-6393 | Fax: 626-585-1522

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Student Name: _____ UID: _____

Date of Birth: _____ Email Address: _____

Address: _____

Phone: _____ Fax: _____

I, the undersigned, hereby authorize Caltech Student Wellness Services to obtain, disclose, or exchange my health information as described below:

☐ Obtain record(s) from: ☐ Release record(s) to: ☐ Exchange verbally with

Name: _____

Address: _____

Phone: _____ Fax _____

If you wish to impose restrictions on the recipient's use of the health information, you must contact them directly.

Reason for Release: I authorize the release/exchange for the following purpose(s):

_____

_____

Information to be disclosed: I authorize the release/exchange of the following health information: (check the applicable box below)

☐ Attendance ☐ Treatment summary ☐ Treatment Recommendations

☐ Entire record - *Fee may apply*; select specific record(s):*

❍ *Medical* ❍ *Counseling* ❍ *Psychiatry* ❍ *Occupational Therapy*

☐ Only the following records or types of health information:

_____

I understand that this request may include information relating to the following, and by initialing below, I specifically authorize the disclosure/exchange of this information. *Unless initialed below, this information will NOT be disclosed or included in copy of records.*

☐ Mental health treatment information:
Counseling _____ (initial) Psychiatry_____ (initial)
☐ Alcohol and/or drug treatment information _____ (initial)
☐ HIV lab test results _____ (initial)

Term: I understand that this Authorization will remain in effect:
☐ From the date of this Authorization until _____, 20____.
☐ Until the Provider fulfills this request.

I understand that:

1. I can revoke this Authorization at any time.
2. My revocation is not effective for disclosures already made and actions already taken while this Authorization was in effect.
3. Treatment or other benefits are NOT dependent on my signing this Authorization.
4. I am authorizing disclosure of information protected under federal and/or state law. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure, in some cases, may not be protected by state and/or federal law. Please note that if you wish to impose restrictions on the recipient's use of the health information, you must contact the recipient directly.
5. A photocopy or facsimile of this authorization shall be valid as the original authorization.
6. This Authorization will remain in effect during the term indicated above or until otherwise revoked by the undersigned client.
7. I am entitled to receive a copy of this authorization.

_____ _____

Signature of Patient or Authorized Representative Today's Date

*FEE SCHEDULE FOR COPIES OF RECORDS: 1-3 pages: no charge 4-10 pages: $5.00 11-20 pages: $10.00 21+ pages: $15.00 plus $.35 per page	Records will be ready for release within 5 business days. Records will be furnished for in-person pick up, fax or sent via postal service. You may be asked to review your record with a clinician prior to receiving a copy. Most providers prefer a treatment summary to a copy of the entire record.

Records Release Office Use Only: Authorized by: _____ Released on: _____