

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

Stu	nt Name: UID:				
Dat	of Birth: Email Address:				
Add	ess:				
Pho	e: Fax:				
	undersigned, hereby authorize Caltech Student Wellness Services to obtain, disclose, on the services to obtain, disclose, or the services to obtain the services				
	Obtain record(s) from: \Box Release record(s) to: \Box Exchange verbally with				
Nar	:				
Add	ess:				
Pho	Phone: Fax				
-	wish to impose restrictions on the recipient's use of the health information, you must ct them directly.				
Rea	on for Release: I authorize the release/exchange for the following purpose(s):				
	nation to be disclosed: I authorize the release/exchange of the following health nation: (check the applicable box below)				
	attendance Treatment summary Treatment Recommendations				
	ntire record - Fee may apply*; select specific record(s):				
	Medical O Counseling O Psychiatry O 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.*

	Counseling _ Alcohol and	th treatment information: (initial) Psychiatry /or drug treatment informat results (initial)			
	From the da	d that this Authorization will te of this Authorization until			
	Until the Pro	ovider fulfills this request.			
I unde	erstand that:				
1.	I can revoke	this Authorization at any tim	ne.		
2.	2. My revocation is not effective for disclosures already made and actions already taken while this Authorization was in effect.				
3.	3. Treatment or other benefits are NOT dependent on my signing this Authorization.				
4.	I am authori Information recipient. Su	zing disclosure of informatio disclosed pursuant to this au uch re-disclosure, in some ca	n protected under federal and/or state law. uthorization could be re-disclosed by the ses, may not be protected by state and/or to impose restrictions on the recipient's use of		
		nformation, you must contac	•		
			ation shall be valid as the original authorization.		
6.			uring the term indicated above or until		
		evoked by the undersigned cl			
7.	I am entitle	d to receive a copy of this au	thorization.		
 Signat	cure of Patier	nt or Authorized Representat	ive Today's Date		
*FEE S	SCHEDULE FOR	COPIES OF RECORDS:	Records will be ready for release within 5 business		
	1-3 pages:	no charge	days. Records will be furnished for in-person pick up,		
	4-10 pages:	\$5.00	fax or sent via postal service. You may be asked to		
	11-20 pages: 21+ pages:	\$10.00 \$15.00 plus \$.35 per page	review your record with a clinician prior to receiving a copy. Most providers prefer a treatment summary to a copy of the entire record.		
Reco	rds Release Offic	ce Use Only: Authorized by:	Released on:		

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