UNIVERSITY OF CALIFORNIA, MERCED

COUNSELING AND PSYCHOLOGICAL SERVICES

5200 North Lake Road, Merced, CA 95343

PHONE: (209)228-4266 FAX: (209)500-6335

AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION

Name: _____ **DOB:** _____ **Cell phone #:** _____
MM/DD/YYYY

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City State Zip code
Phone: _____ FAX:_____

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City State Zip code
Phone: _____ FAX:_____

I AUTHORIZE the following information to be disclosed for the following date(s): _____
(Please initial all that apply)

_____ Entire Record _____ Appointment History _____ Attendance

_____ Letter _____ Phone Call

_____ Only the following information:_____

_____

REASON for disclosure of mental health information: (Please initial one)

_____ At my request _____ Job _____ Academic

_____ Insurance _____ Legal _____ Continuing coordination of care

____ Other (specify)_____

EXPIRATION of this authorization: (Please initial one)

_____ 90 days after signature date_____ _____ On this date: _____

_____ When this event happens: _____

ADDITIONAL CLIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.*
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my mental health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by the University of California, Merced, Counseling and Psychological Services.
- I understand that signing this authorization does not cancel any rights I have under other state or federals laws.

_____ **Date:** _____

Student Signature (Parent or Legal Representative, if applicable)

*** I wish to withdraw this authorization:** _____ **Date:** _____

Please allow up to ten (10) business days for staff to process your request.

For office use only: ___Pick-up records ____ Mail Records ____ Fax records Date ROI received: _____ Initial: _____ Date ROI faxed: _____ Initial:_____ Student ID#: _____	Date records received if applicable: _____ Received by (initial): _____ Provider acknowledgement: (initial)_____ Name: _____