California State University
SAN MARCOS

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AUTHORIZATION TO RELEASE INFORMATION

I, _____, Student ID:_____, D.O.B._____
(print name)
authorize my counselor(s) at Student Health & Counseling Services at California State University San Marcos to exchange information with:

_____ _____
Name Title/Position

_____ _____
Agency Street Address

_____ _____
City, State & Zip Phone # Fax#

The following may be ☐ released and/or ☐requested:

- Dates/verification of services ☐Yes ☐No
- Case summary ☐Yes ☐No
- Psychological test results ☐Yes ☐No
- Psychotherapy Notes ☐Yes ☐No
- Other:_____ ☐Yes ☐No

For the purposes of:

- Assessment/evaluation ☐Yes ☐No
- Treatment planning ☐Yes ☐ No
- Referral ☐Yes ☐No
- Consultation pertaining to academic-related concerns ☐Yes ☐No
- Other:_____ ☐Yes ☐No

I understand that Counseling and Psychological Services is released from legal liability arising from this exchange of information. This authorization shall remain valid until _____/_____/_____ (maximum of six months).

_____ _____ _____
Client's Signature Date Phone Number

_____ _____
Parents'/Guardians' Signatures (if applicable) Date

_____ _____
Authorized Staff Member's Signature Date

10/22