

UNIVERSITY OF HOUSTON - CLEAR LAKE

Counseling Services

(281) 283-2580

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name: \_\_\_\_\_

Student Number: \_\_\_\_\_

\_\_\_\_\_(initial) I hereby give permission to UHCL Counseling Services to release, orally or in writing, information concerning me to the person or agency named below.

\_\_\_\_\_(initial) I hereby give permission to the person or agency named below to release, orally or in writing, information concerning me to UHCL Counseling Services.

UHCL Offices and Services:

( ) Career Services ( ) Connecting to College Program ( ) Dean of Students Office ( ) Accessibility Support Center

( ) Health Services ( ) Student Financial Aid Office ( ) Student Success Center ( ) Title IV

( ) Faculty/Staff/Other office (Name) \_\_\_\_\_

( ) Non-UHCL Person or Facility (Name) \_\_\_\_\_

(Address) \_\_\_\_\_

(Phone) \_\_\_\_\_ (email) \_\_\_\_\_

The information to be disclosed is checked below:

( ) Mental health evaluations ( ) Medical history, evaluations, treatment

( ) Progress notes, and treatment or closing summary

( ) Other: \_\_\_\_\_

The information to be released is for the following purpose(s):

( ) Mental health evaluation, treatment or care ( ) Medical evaluation, treatment or care

( ) Rehabilitation program development or services ( ) Treatment coordination or planning

( ) Other: \_\_\_\_\_

Information may be communicated verbally in person or by phone or in writing by mail, fax or email.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that information released to UHCL personnel (outside of Counseling Services or Student Health Services) is considered a student educational record covered by privacy rules of the federal Family Educational Rights and Privacy Act (FERPA) and as such may be shared with officials of UHCL with a legitimate need to know. I understand that I may take back this consent at any time within one year, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed or upon fulfillment of the purposes stated above.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date