

UNIVERSITY OF HOUSTON - CLEAR LAKE

Counseling Services
(281) 283-2580

Health Services
(281) 283-2626

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Name: _____

Student Number: _____

_____(initials) I hereby give permission to UHCL Counseling Services and UHCL Health Services to exchange with each other, orally or in writing, the following information concerning me.

The information to be disclosed and exchanged is checked below:

() Mental health history, evaluations, treatment () 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: _____

I have had explained to me and fully understand this authorization to release and exchange records and information, including the nature of the records, their contents, and the consequences and implications of their release. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. I understand that the provision of appropriate mental health services at UHCL requires the exchange of information between Counseling Services and Health Services. 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 Professional

Printed name

Date