Stanford | Vaden Health Center

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION BETWEEN COUNSELING AND PSYCHOLOGICAL SERVICES AT STANFORD AND ANOTHER PERSON OR AGENCY

I, the undersigned, hereby authorize and consent to the following:

The disclosure of the following information:

☐ Clinical information
☐ Other: _____

For the following purpose(s):

☐ OAE Accommodations ☐ Attendance/participation in treatment ☐ Transfer of Care
☐ Coordination of treatment ☐ Discussion of progress made in treatment
☐ Other: _____

Disclosure Between:	
Counseling and Psychological Services **Vaden Health Center** **Stanford University** **866 Campus Drive** **Stanford, CA 94305-8580** **Phone: 650.723.3785** **Fax: 650 725.2887**	☐ Residence Dean ☐ Graduate Life Office ☐ OAE ☐ UAR ☐ Bing Overseas ☐ Other:_____ *(Name and address or phone number of other organization, class of persons and/or person to which information is shared)* _____ _____ _____ _____

This authorization is subject to revocation at any time, *by written notification only*, except to the extent that CAPS already disclosed the information, and expires within one year unless otherwise stated: _____

(Insert date, event or condition upon which it will expire)

I understand that: (a) the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected, (b) I may refuse to sign this authorization, and that Counseling and Psychological Services may not condition my treatment upon whether I sign it, and (c) I am entitled to a copy of this authorization.

Signature: _____ **Date:** _____

Print Name, Date of Birth, and SUID#: _____

(If a personal representative of the patient signs this authorization, a description of such representative's authority to act for the patient must be provided)

Witness: _____