AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION TO COUNSELING AND PSYCHOLOGICAL SERVICES AT STANFORD UNIVERSITY

I, the undersigned, hereby authorize and consent to the disclosure of the specific information listed in this document.

DISCLOSURE TO	DISCLOSURE BY
Counseling and Psychological Services **Vaden Health Center** **Stanford University** **866 Campus Drive** **Stanford, California 94305-8580** **Phone: 650.723.3785** **Fax: 650 725.2887**	*(Name and address of organization, class of persons and/or person to which disclosure is to be made)* _____ _____ _____ _____ _____

For the following purpose or need:

_____

_____

_____

The disclosure of the following specific information is authorized:

_____

_____

_____

If more space is needed, use back of this form and sign it

This authorization is subject to revocation at anytime, *by written notification only*, except to the extent that CAPS already disclosed the information, and in any case expires:

_____

(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 and Date of Birth) _____

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

_____

(Witness)