

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION
From Treating Professional
To CAPS and SHC Staff**

(Name of Client)

(UR ID #)

* * * * *

I HEREBY AUTHORIZE:

Name of Treating Health Professional: _____

Phone Number of Treating Health Professional: _____

TO SHARE THE FOLLOWING CONFIDENTIAL HEALTH INFORMATION:

(1) Specific information requested on the "Treatment Summary and Recommendations" form

(2) Any other relevant health information

(3) Other: _____

WITH COUNSELING AND PSYCHOLOGICAL SERVICES (CAPS) AND STUDENT HEALTH CENTER (SHC) STAFF AT THE UNIVERSITY OF RICHMOND.

FOR THE PURPOSE OF:

(1) Determining readiness to return to the University of Richmond

(2) Coordinating treatment

(3) Other: _____

(Student's Signature)

(Date Signed)

This release will be invalid one year after the date of authorization cited above.

I understand that I have the right to revoke this authorization in writing at the CAPS, SHC and treating professional offices at any time, unless CAPS, SHC, and or my treating professional have already acted upon it.