STUDENT PSYCHOLOGICAL SERVICES

1000 E. VICTORIA STREET
CARSON, CALIFORNIA 90747
310.243.3818

RELEASE OF INFORMATION

____

(Client's Name) *(Date of Birth)* *(Student ID)*

Client initials all that apply:

_____ 1) I, The above named party, give permission for the following outside agency or practitioner:

____

____

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To release information to: ____

(Practitioner of California State University, Dominguez Hills)

____ 2) I give permission for the above-named parties to exchange information about my case.

____ 3) I give permission for ________________________________ to release information to:

(Practitioner of California State University, Dominguez Hills)

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The records I authorize to be released or exchanged are:

□ Confirmation of Treatment □ Summary Date Counseling Records
□ Counseling/Psychological Records □ Medical Records □ Assessment Information
□ Other ____

I have initialed the options with which I agree. This authorization expires one year from the date listed below unless otherwise indicated.

____

Client's Signature Date

____

Witnessed By: Date

"This information has been disclosed to you from the counseling files of CSU, Dominguez Hills

The intentional redisclosure of the information may subject you to a civil action under Section 1798.53 of the Civil Code for invasion of privacy by the individual(s) to whom the information pertains.

You are advised to be certain of your authority to further disclose any of this information before doing so.