Peggy H. Smith Counseling Clinic, Burk Hall 117
San Francisco State University
1600 Holloway Avenue San Francisco, CA 94132

Authorization for Release/Request of Information

Name: _____ **Student ID:** _____ **DOB:** _____

Please check after reading:

[ ] Peggy H. Smith Counseling Clinic maintains your records as strictly confidential.

[ ] I have the right to receive a copy of this request.

[ ] I understand that if the person(s) or organization(s) authorized to receive the information is not a health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

[ ] I understand that I have the right to revoke this authorization at any time with written notice.

[ ] If written records are to be sent, I give my permission for the records to be faxed or mailed.

Purpose of Disclosure (Please check):

[ ] Continued care / consultation **[ ]** Academic related **[ ]** Referral

[ ] Other:_____

Information to be Disclosed (Please check):

[ ] Dates of treatment **[ ]** Type(s) of treatment

[ ] The following specific information:_____

_____

_____ I authorize the Peggy H. Smith Counseling Clinic to release the above information **to** the person/provider/
initial agency named below.

_____ I authorize to have the above information released **from** the person/provider/agency named below to the
initial Peggy H. Smith Counseling Clinic.

Name of Person/Provider/Title:_____

Name of Agency/Department/Relationship:_____

Mailing/Campus Address: _____

Phone Number:_____ **Fax Number:** _____

This authorization is effective as of the date of signature. The authorization will expire by the end of the academic year or _____.

Client Signature: _____ **Date:**_____

Witness/Counselor Signature & Name: _____ **Date:**_____

Supervisor Signature & Name: _____ **Date:**_____

For Office Use ONLY

Record requested/released by:_____ Date:_____

Record requested/released by:_____ Date:_____