AUTHORIZATION FOR RELEASE OF INFORMATION

Wesleyan University Counseling and Psychological Services

327 High Street

Middletown, CT 06459

Patient/Client Name: _____ **DOB:** _____

I authorize staff of Wesleyan University Counseling and Psychological Services to communicate to/from the person or agency listed below:

Name: _____

Address: _____

Phone/Fax: _____

Information to be released or exchanged:

__Medical History __ Medication Records

__ Psychiatric History __ Psychiatric Assessment/Evaluation

__ Psychological Assessment __ Physical Exam/Assessment

__ Progress Notes __ Diagnostic Tests

__ Social History __ Discharge Summary

__ Substance Abuse History __ Alcohol Abuse History __ Legal History

__ Other_____

This information is to be released for the following purpose:

__Treatment Planning __Treatment Coordination __Facilitation of Referral

__ Clinical/Administrative/Academic. Other: _____

This authorization of release pertains only to the above-specified information and to the above-specified parties. I also understand that I may revoke this authorization at any time in writing except to the extent that CAPS has already taken actions in reliance on it, and that the authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

Signature: _____ **Date:** _____

Wes ID: _____

Witnessed by (Staff Member): _____ **Date:** _____

Signature: _____