

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

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)