Stanford | Vaden Health Center

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION BETWEEN VADEN HEALTH SERVICES AND ANOTHER PERSON OR AGENCY

I, the undersigned, hereby authorize and consent to the following disclosure of information:

Disclosure Between:	
Vaden Health Services - Stanford University *(check all Vaden units that apply)* ☐ Medical Services Phone: 650-498-2336, opt 1 Fax: 650-723-1600 ☐ Counseling and Psychological Services (CAPS) Phone: 650-723-3785 Fax: 650-725-2887 ☐ Confidential Support Team (CST) Phone: 650-736-6933 Fax: 650-497-0502 ☐ Weiland Health Initiative Phone: 650-723-0821 ☐ Other *(please specify)*: _____ _____	*Entity with whom information will be shared:* ☐ Dean of Students Office (DoS) ☐ Graduate Life Office (GLO) ☐ Residential Education Office (ResEd) ☐ Office of Accessible Education (OAE) ☐ Academic Advising ☐ Bing Overseas Studies Program (BOSP) ☐ Provider(s) *(list type, past/current, name, and contact info):* _____ _____ ☐ Family *(list name(s) and relationship(s))*: _____ _____ _____ ☐ Other *(please specify)*: _____ _____ _____

For the following purpose or need:

☐ OAE accommodation(s) ☐ Attendance/participation in treatment ☐ Transfer of care
☐ Coordination of treatment ☐ Discussion of progress made in treatment ☐ Other: _____

The disclosure of the following specific information (from the Vaden unit checked above) is authorized:

☐ Clinical information to address the stated purpose above ☐ Other: _____
☐ Clinical information associated with the following conditions _____

The authorization is subject to revocation at any time, *by written notification only*, except to the extent that the information has already been shared/disclosed, and expires within a year unless otherwise stated:

_____

(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 Vaden Health 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, Date of Birth, and SUID#) _____

Effective 09.18.25