California State University, East Bay
Student Health and Counseling Services
25800 Carlos Bee Blvd.

Authorization to Release/Exchange Information

I hereby request and authorize the following parties to release and/or exchange information about my mental health treatment:

___ All Relevant Information
___ Intake Report
___ Diagnosis
___ Progress Notes
___ Discharge Summary
___ Verification of Counseling Services
___ Other, specify:

Name: _____

Organization: _____

Address: _____

Phone: _____ FAX: _____

This information is to be exchanged for the following purpose: _____

I authorize the release of the above information for the following dates:

____ All dates of contact. OR Specify: _____

I understand that I may revoke this authorization at any time in writing, but that the request shall remain valid until revoked or upon the expiration of one year from the time t_f onis