

Instructions for Requesting....

1. **Access request form on the Counseling and Mental Health Center - Privacy and Confidentiality**
 - a. Navigate to the bottom and select the General Release of Information Form - DocuSign from from the Downloadable Documents menu.

Downloadable Documents

- [Client Handbook \(PDF\)](#)
- [Notice of Privacy and Confidentiality Practices \(PDF\)](#)
- [General Release of Information Form \(PDF\)](#)
- [Psychiatry Informed Consent \(PDF\)](#)
- [Psychiatry Release of Information for Health Services \(PDF\)](#)

2. **The DocuSign Powerform will open to the PowerForm Signer Information**

PowerForm Signer Information

Fill in the name and email for each signing role listed below.
Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Client

Your Name: *

Your Email: *

BEGIN SIGNING

3. **A message will populate at the top of the form asking to “Please review the documents below.” Click on the box, then on “Continue.”**

University of Houston Clear Lake

Division of Student Affairs

Counseling and Mental Health Center

Please review the documents below.

CONTINUE

FINISH LATER

OTHER ACTIONS ▾

a.

4. The form is now available for data entry, to fill out the form

- a. Enter your Student ID below your name that was populated based on the data you provided on the previous screen.

Name: Hunter Hawk

Student Number:

b. Initial to allow communications between CMHC and another office or individual

_____(initial) I hereby give permission to UHCL Counseling and Mental Health Center to release, orally or in writing, information concerning me to the person or agency named below.

_____(initial) I hereby give permission to the person or agency named below to release, orally or in writing, information concerning me to UHCL Counseling and Mental Health Center.

c. Check the box(es) of UHCL Offices to whom you would like us to release information

If Faculty/Staff/Other office selected, type the name of the faculty or staff member or the office.

UHCL Offices and Services:

- Career Services Connecting to College Program Dean of Students Office Accessibility Support Center
 Health Services Student Financial Aid Office Student Success Center Title IV
 Faculty/Staff/Other office (Name) _____

d. Check this box if records are to be released to a Non-UHCL Person or Facility and give all contact details

- Non-UHCL Person or Facility (Name) _____
(Address) _____

(Phone) _____ (email) _____

e. Check box(es) of what information you would like released. If you are unsure, you can check "Other" and write in your response.

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The information to be disclosed is checked below:

- Mental health evaluations Medical history, evaluations, treatment
- Progress notes, and treatment or closing summary
- Other: _____

f. Check box(es) to indicate why you want the information released.

The information to be released is for the following purpose(s):

- Mental health evaluation, treatment or care Medical evaluation, treatment or care
- Rehabilitation program development or services Treatment coordination or planning
- Other: _____

g. Sign electronically and fill in your phone number. You must provide a good contact phone number so that the Counseling and Mental Health Center front desk can reach out with questions or next steps. Please ensure that you are set up to receive messages at the number you provide. If we cannot reach you, your request may not be processed.

Information may be communicated verbally in person or by phone or in writing by mail, fax or email.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. **I understand that information released to UHCL personnel (outside of Counseling and Mental Health Center or Student Health Services) is considered a student educational record covered by privacy rules of the federal Family Educational Rights and Privacy Act (FERPA) and as such may be shared with officials of UHCL with a legitimate need to know.** I understand that I may take back this consent at any time within one year, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed or upon fulfillment of the purposes stated above.



Signature of Client

Hunter Hawk
Printed Name

3/13/2024
Date

Contact Phone Number

5. Submit the form to Counseling and Mental Health Center by clicking FINISH.

FINISH

Ready to Finish?

You've completed the required fields. Review your work, then select **FINISH**.

FINISH