UNIVERSITY OF HOUSTON - CLEAR LAKE

Counseling and Mental Health Center

(281) 283-2580

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Name: ____

Student Number: ____________________________________

______(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.

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) ____

( ) Non-UHCL Person or Facility (Name) ____

(Address) ____

____

____

(Phone) ______________________ (email) ___________________________

The information to be disclosed is checked below:

( ) Mental health evaluations ( ) Medical history, evaluations, treatment
( ) Progress notes, and treatment or closing summary
( ) Other:____

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:____

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	Printed Name	Date
______________________________	______________________________	______________
Signature of Witness	Printed Name	Date

State law requires that you be informed of the following: (1) you are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law), (2) you are entitled to receive and review that information; and (3) you are entitled to have the information corrected at no charge to you. 07/31/2023