UNIVERSITY OF HOUSTON-CLEAR LAKE

Counseling and Mental Health Center
(281) 283-2580

Health Services
(281) 283-2626

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Name: _____

Student Number: _____

_____(initials) I hereby give permission to UHCL Counseling and Mental Health Center and UHCL Health Services to exchange with each other, orally or in writing, the following information concerning me.

_____(initials) I understand that if I am prescribed a stimulant as part of my treatment, certain information will be shared with the psychiatric provider's supervising physician, Mark Im, M.D., for purposes of prescribing. I am also aware that this means that relevant portions of my file may be stored in an off-site, second location in a confidential, encrypted medical records system.

Should you have any additional questions or concerns, please feel free to discuss them with the UHCL psychiatric provider during your appointment or contact the supervising physician, Dr. Mark Im at (832) 545-4560.

The information to be disclosed and exchanged is checked below:

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

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

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

I have had explained to me and fully understand this authorization to release and exchange records and information, including the nature of the records, their contents, and the consequences and implications of their release. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. I understand that the provision of appropriate mental health services at UHCL requires the exchange of information between the Counseling and Mental Health Center, Health Services, and in certain instances, Mark Im, M.D.

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 Professional	Printed name	Date

Revised 7/31/2023