CAL STATE
EAST BAY

AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Birthdate:_____NetID:_____

I hereby authorize the following information (check all that apply):

YES	NO	Type of information
☐	☐	**Administrative information** (e.g., name, age gender identity, phone number, address, email, identifying numbers, dates and character of service, etc)
☐	☐	**Mental health treatment information** (e.g., summary of initial concerns, symptoms, course of treatment, termination of treatment, etc)
☐	☐	**Substance use treatment information** (e.g., current and past use, course of treatment, treatment recommendations, termination of treatment, etc)

to be shared between: Name: _____Relationship to patient:_____

Phone:_____Email:_____

and: California State University, East Bay
25800 Carlos Bee Boulevard
Hayward, CA 94542
Phone: 510-885-3735
Fax: 510-885-3230
Email: shcs@csueastbay.edu

except information pertaining to:_____

For the purpose of: ☐Consultation ☐Continuity of care ☐ Other:_____

Date, event, or condition upon which this authorization expires:_____

I understand that my authorization may be revoked at any time. Unless previously revoked**, this authorization will terminate on June 1st of the current academic year.**

I understand I have a right to receive a copy of this authorization form upon my request.
Copy requested and received: Yes:__ No:_____

I am signing this authorization voluntarily and understand that my mental health treatment will not be affected if I do not sign this authorization.

_____ _____
Patient Signature *(or Parent/Guardian Signature if patient is under 18)* Date

Relationship to Patient:_____