UNIVERSITY OF ARKANSAS
COUNSELING AND PSYCHOLOGICAL SERVICES
525 North Garland Avenue
1 University of Arkansas
Fayetteville, Arkansas 72701-1201
(479) 575-5276

CAPS Use Only

Copy given to client?
☐ Yes
☐ No

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I,			
	Name	Student ID#	Date of Birth
	Address		Telephone Number
authorize			
to **release and request** the following information from my records:			
Psychiatric Evaluation, Psychiatric Progress notes, medication contacts, conversation between my provider and this office regarding my psychiatric care.			
To/From	Counseling and Psychological Services, 525 N. Garland Ave., U of A, Fayetteville, AR 72701		
for the purpose of	Continuity of care		

The information incorporated in this release has been explained to me.

I understand the following: (a) the exact nature of the information to be released; (b) to whom the information is being released; (c) why the information is being requested and how it will be used; (d) that the receiving party will be instructed not to release the information to other individuals or agencies; and (e) that I am responsible for any repercussions which might occur due to my release of or failure to release the information specified above. I also understand that I may revoke this authorization at any future point in time by filling out the section at the bottom of this page. However, I understand that once the requested information is released, CAPS has no further control or responsibility as to the use or re-release of the released information. This authorization will expire one year from date unless revoked prior to that time.

(Signature of Client)	(Date)		(Signature of Witness) (Date)

STATE OF ARKANSAS
COUNTY WASHINGTON

Subscribed and sworn to before me a Notary Public on this the _____ day of _____, 20__.

-SEAL-

_____
Signature of Notary Public or other authorized official

I revoke the above permission on this Day: _____ _____ am/pm
Date Time

_____ _____
Client Name (Please print) Client Signature

_____ _____
Witness Name Witness Signature

***Please Note**: This form must be signed and dated by the client and a witness (who verifies the client's informed consent) before the request for release of confidential information can be processed.*