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Academic & Staff Assistance Program

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name:_____ Date of Birth: _____

I hereby authorize counselors in the UC Santa Barbara Academic & Staff Assistance Program (ASAP) to share and exchange information from my counseling records to:

Name:_____ Relationship: _____

Phone: _____

Address:_____ Email or FAX: _____

Purpose of exchange of information and disclosure: _____

Disclosure shall be limited to the following types of information:

- ☐ Attendance only
- ☐ Summary of record
- ☐ Results of psychological assessment
- ☐ Unrestricted communication
- ☐ Other:_____

I wish to limit disclosure as follows:

This information will be provided in the following way(s):

☐ Written ☐ Verbal

☐ Email or FAX ☐ All of the above

By signing below, I acknowledge that I have read and understand this Authorization:

1. I understand that all ASAP records will be reviewed by an ASAP counselor prior to release of confidential information.
2. I understand that I have the right to review and receive a copy of my full records, including the current Authorization form. I understand that I can request a copy of this form after I sign it.
3. I understand that, unless withdrawn, this authorization will expire 365 days from the date of signature. A photocopy of this form will be considered as valid as the original.
4. I understand that I may revoke this authorization at any time by notifying ASAP at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent that action has already been taken in reliance upon it.
5. I fully comprehend the issues concerning privacy, confidentiality, and my right to forfeit signature of this authorization form. I understand that if I authorize disclosure of my health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.
6. I realize that my eligibility for services is not conditional upon my compliance with authorizing this form.

_____ _____

Signature of client OR legal guardian/authorized person Date

_____ _____

Signature of witness Da

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