

CALIFORNIA INSTITUTE OF TECHNOLOGY
Counseling Services
CONSENT FOR RELEASE OR EXCHANGE OF INFORMATION

I, _____, on _____, authorize
Name of Client Today's Date

the California Institute of Technology Counseling Center, where I am or have been a client,

____ (*initial here*) to discuss verbally or in writing any information that has been brought up during psychotherapy with the person/s named below;

____ (*initial here*) to receive any relevant information from the person/s named below.

_____ phone _____

_____ phone _____

_____ phone _____

_____ phone _____

This authorization permits the release and exchange of any information necessary for the purpose of:

____ Academic Accommodation

____ Determining Academic Status/Leave of Absence

____ Coordination of Treatment and/or Evaluation

____ Facilitation of Referral

____ Other (please specify): _____

With the following limitations, if any: _____

I understand that this release expires at the date below and can be revoked at any time with written notification. I understand that I have the right to receive a copy of this authorization.

Signature of Client (or client representative, if applicable) Expiration Date of Release

Witness