Eric Cohen Student Health Center of USC
Keck Medicine of USC

Authorization for Release of Information

Student Counseling Services
1510 San Pablo St., Ste. 104
HealthCare Consultation Center I, 1st Floor
Los Angeles, California 90033
Ph: (323) 442-5631 Fax: (323) 442-6029

Student's Name: _____

10-digit USC I.D. # _____

Date of Birth: ____/____/____ Today's Date: ____/____/____

I hereby voluntarily authorize Student Counseling Services to:

☐ Release info to: _____

☐ Obtain info from: _____

☐ Exchange info with: _____

the following information pertaining to myself:

☐ Treatment summary
☐ Intake summary
☐ Diagnosis
☐ Psychological Test Results
☐ Psychiatric Evaluation & Treatment
☐ Dates of Treatment Attendance
☐ Other, Please specify: _____

for the purpose of: _____

I have been told that in order to protect the confidentiality of records, my consent to the release of this information is necessary and that this permission is limited to the person listed above, and will be effective only during the dates listed. I understand that I may withdraw my permission at any time by written request. A copy of this authorization is as valid as the original. This authorization is effective immediately and shall remain in effect for six (6) months or until: _____.

_____ _____
Signature of Client Date Signature of Witness Date

_____
Signature of Clinician Date

NOTICE TO ANY PARTY RECEIVING CONFIDENTIAL INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by federal and state law. Regulations prohibit you from making any further disclosure of this information without the prior consent of the person to whom it pertains.