Regis University Counseling Services
3333 Regis Boulevard, F-12
Denver, Colorado 80221-1099
303-458-3558/Fax: 303-964-5406

AUTHORIZATION TO RELEASE INFORMATION

Student Name____________________________ Regis ID___________________________

Date of Birth__________ Contact Phone Number ______________

I authorize Regis University Counseling Services to:
Release/Request the following information: ☐ TO ☐FROM ☐Both TO & FROM

Please check ALL that apply:

☐Regis Athletics
☐Housing
☐Veteran Affairs
☐ VP of Student Affairs
☐Financial Aid
☐Student Conduct
☐Dean of Students
☐Learning Commons
☐Faculty
☐Diversity, Equity, and Inclusive Excellence
☐Disability Services
☐Health Services
☐Regis Care Team (Student Conduct)
☐University Ministry
☐VAVP
☐Office of Engagement
☐Career Counseling
☐Other

____ ____

The information exchanged may include:
☐Verbal Communication (specify): ____
☐ Support letter information pertaining to mental health visit attendance (dates/number of visits)
☐Information pertaining to mental health treatment notes (Documented contacts)
☐Information pertaining to treatment summary (Closing summary—includes number of sessions, diagnosis, focus of treatment, treatment progress)
☐Information pertaining to psychological assessment
Therapist shall not condition treatment upon client signing this authorization and client has the right to refuse to sign this form. The client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Colorado law may protect such information. I understand that I may revoke this authorization to release/request information, except to the extent that the therapist has taken action in reliance thereon, by giving written notice to Regis University Counseling Services. Without such revocation, this authorization shall expire on ___/___/_____ , or if left blank, six months following termination of treatment. I release Regis University Counseling Services from all liability for releasing such information.

____ ______________
Client/Representative Signature Date

❑ I hereby revoke this Authorization to Release/Request Information

____ _______________
Client/Parent/Legal Guardian Signature Date
A copy or facsimile of this authorization is as valid as the original.