



Caltech Accessibility Services for Students
 Center for Student Services
 Phone: 626.395.6352 (undergraduates)/626.395.6346 (graduate students)
 Email: cass@caltech.edu

Medical Consent Authorization Form

This form must be completed and signed by you and returned to the Caltech Accessible Student Services (CASS) office.

Date: _____ Name of Student: _____

Student Release of Medical Information:

To: _____
 (Name of Treating Provider)

 (Address of Treating Provider)

I, the undersigned, hereby authorize the provider identified above to provide to and discuss with representatives of CASS any and all medical and other confidential records and information which is required with respect to my diagnosis, prognosis, and/or duration of disability for the purpose of evaluating my request(s) for academic adjustments and other reasonable accommodations in relation to my student status at Caltech.

I understand that this request may include information relating to the following, and by initialing below, I specifically authorize the disclosure/exchange of this information. Unless initialed below, this information will NOT be disclosed or included in copy of records.

Mental health treatment information:

Counseling _____ (initial) Psychiatry _____ (initial)

Term: I understand that this Authorization will remain in effect:

From the date of this Authorization until _____, 20____.

Until the Provider fulfills this request.

I understand that:

1. I can revoke this Authorization at any time.
2. My revocation is not effective for disclosures already made and actions already taken while this Authorization was in effect.
3. A photocopy or facsimile of this authorization shall be valid as the original authorization.
4. This Authorization will remain in effect during the term indicated above or until otherwise revoked by the undersigned.
5. I am entitled to receive a copy of this authorization.

 Signature of Patient or Authorized Representative

 Date