THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Services

PERMISSION FOR TELEPHONE CONSULT/ RELEASE OF INFORMATION (CAPS)

I grant permission for Aaron T. Barnes, PsyD, Patti Norris, LPC/ CAPS _____
Name of CAPS Provider

to discuss my visit(s) / attendance _____ to _____ at:

☐ Counseling and Psych Services (CAPS) ☐ Other: _____

WITH: Please Specify and check off

☐ General Medicine ☐ Nutrition ☐ Pharmacy ☐ Physical Therapy ☐ Sports Medicine

☐ Urgent Care ☐ Women's Health Clinic ☐ Arizona Housing and Res Life

☐ Arizona Title IX Office

☐ Arizona Department/Organization _____

☐ DOS/BIT _____

☐ Other: _____
Name of Person to be Consulted *Telephone Number*

My provider has discussed the purpose of this telephone consult
with me and I give my permission for my information to be released:
(Please initial inside one of the circles and specify if there are exception)

◯ without any exception

◯ with the following exceptions: _____

_____ _____
Signature (signed electronically) *Date*

_____ _____
Printed Name *Student I.D. Number*

COUNSELING & PSYCH SERVICES (CAPS)
The University of Arizona / Campus Health Service
www.health.arizona.edu

CAPS MAIN OFFICE
1224 E. Lowell Street 3rd Floor Tucson AZ 85721
Phone: 520-621-3334 FAX:520-626-6105

CAPS NORTH OFFICE
1051 E. Mabel Street 2nd Floor Tucson AZ 85719
Phone: 520-626-3100 FAX: 520-626-2394

Fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), Inc.