UNIVERSITY COUNSELING CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

I. Client Name: ______________________________________Date of Birth:__________________________
(please print)

Address:____Phone Number: ______________________

____

II. I hereby authorize the University Counseling Center to

_____ release to
_____ obtain from
_____ exchange with

Name:____

Address:____

____

_______________________ _______________________
(phone) *(fax)*

III. The following information:

_____ treatment summary
_____ dates of treatment
_____ psychological evaluation
_____ diagnosis and nature of condition
_____ psychiatric evaluation/medication history
_____ medical withdrawal/re-enrollment summary
_____ other *(specify)*____

IV. For the purpose of:

_____ contact with referral source
_____ academic planning
_____ evaluation/assessment
_____ coordination of care
_____ continuity of treatment
_____ medical withdrawal/re-enrollment
_____ other *(specify)*____

V. Type of Disclosure Requested:

_____ oral
_____ electronic
_____ letter

This authorization is given voluntarily with my full realization that the information is confidential material. I understand that I may cancel this authorization at any time by submitting a written request to the UCC, except where a disclosure has already been made in reliance on my prior authorization. A copy of this authorization shall be considered as valid as the original.
Expiration of Authorization: Unless otherwise canceled, this Authorization expires on _____________.
If no date is indicated, the Authorization will expire 12 months after the date of your signature.

VI. **Client Signature: ____Date: ______________**

Witness Signature:____Date:_______________

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