

AUTHORITY TO RELEASE INFORMATION

I, _____, hereby authorize
_____ to release my
(Name of specific person/organization and address)

treatment records or information concerning such records to the University Counseling
Center for the purpose of: _____
(Specific reason for release of information)

I specifically consent only to the release of information or medical records pertaining to:

(Specific nature & extent of information)

I understand that I may revoke this consent at any time except to the extent such action has
been taken thereon. I further understand that this consent will expire _____
(Not to exceed 6 months)
without my **WRITTEN** consent.

(Signature of Client) (Date)

(Signature of Witness) (Date)

Client Identifying Data: _____
Last Name First Middle

Social Security # Birth Date Sex Race Initial Contact Date

****+++NOTE TO RECEIVER+++****

This information has been disclosed to you from records of whose confidentiality is protected. Statutes/regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is **NOT** sufficient for this purpose.