Counseling Services

Division of Career Development

Athens State University, 300 N. Beaty Street, Athens, AL 35611 256.233.8144

www.athens.edu/counseling

Authorization to Release/Exchange Confidential Information

This form cannot be used for the re-release of confidential information provided to Counseling Services by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____ authorize ASU Counseling Services to:

__✓__ release to:

_____obtain from:

_____exchange with:

The following information pertaining to myself:

_____treatment summary

_____history/intake

_____diagnosis

_____psychological test results

_____psychiatric evaluation/medication history

__✓__dates of treatment attendance

_____other (specify) _____

For the purpose of:

_____evaluation/assessment and/or coordinating treatment efforts

_____other (specify) _____

This consent will remain valid until client designates in writing otherwise.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.)

Signature of Client/Date/DOB

_____

Signature of Witness/Date

_____