RELEASE OF INFORMATION FORM

SIU SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
STUDENT HEALTH SERVICES

I hereby authorize SIU Counseling & Psychological Services to: _____ disclose _____ exchange information in the form of record copies and professional communications about:

Client's full name _____

Regarding evaluation, treatment, counseling and psychological testing to/with:

Name of person and/or agency _____

Address _____

_____

Telephone _____ Fax _____

This disclosure/exchange is requested for the purpose of:

_____ Facilitating continuing psychological treatment:

_____ _____

_____

I acknowledge that I have been informed of my rights as a client. I understand that I have the right to inspect and copy the information to be disclosed. I have the right to revoke this authorization in writing at anytime. I understand that I am signing this release voluntarily and failure to sign it will not affect my ability to receive treatment. I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations. My consent is given from the signature date of this document through:

(allow at least six months) _____

I understand that I may revoke my consent in writing at any time.

Signature of Client _____ Date _____

Address _____

Phone _____ Dawg Tag _____ Date of Birth _____

Counselor's name _____ Signature of witness _____

We have been authorized to release this confidential information to the person and/or agency listed above. It is not to be recopied or released to any other person or agency.

CONTACT INFO

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