



AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

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

I _____ authorize the Counseling Center 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) _____



Marnee Alfson, MA, LMHCA

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

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).

_____ Social Security #: _____

Signature of Client

Date

OR

Date of Birth: _____

Signature of Witness

Date