University Counseling & Wellness
Authorization for Release of Information

Client Name: _______________________________ Date: ________________

Address: ___________________________ City: ___________________________ State: _____ Zip: _____________

Personal Contact/ Phone: _______________ Email: ______________________

I, the undersigned, voluntarily authorize the release and exchange of confidential information between Samford University Counseling & Wellness and:

________________________________________________________________________________________
Person/Organization

________________________________________________________________________________________
Department /Address

________________________________________________________________________________________
Phone Number

City/State/Zip

Type of disclosure authorized: ___ Verbal Report; ___ Copies of Records; ___ Letter; ___ E-mail

Information to be released: ___ Mental Health Assessment; ___ Progress Update/Treatment Plan;
___ Other (specify) _______________________________________________________________________

The purpose of releasing this information is: ___ At the Request of the Individual;
___ Aid in diagnosis and treatment planning; ___ Aid in university educational and administrative procedures;
___ Other (specify): _______________________________________________________________________

This authorization is valid from date of client signature to _______

If no date is indicated, this authorization will expire 12 months from date of client signature.

I understand that I am entitled to a copy of this authorization, and that I may choose to terminate this authorization at any time by notifying Counseling & Wellness in writing.

_________________________________________ ______________________
Client Signature Date

_________________________________________ _________________
Counselor Signature Date

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