

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

Phone Number

Department /Address

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