Samford University
Counseling Services

University Counseling Services & Wellness Programs

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 Services 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 Services in writing.

____ ___________________
Client Signature Date

____ ___________________
Counselor Signature Date