

STUDENT COUNSELING SERVICES

118 Foy Union
Auburn University, Alabama 36849-5369
(334) 844-5123

CLIENT AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I, _____, hereby authorize
_____, or a Student Counseling Services
representative, to obtain from and/or release to _____

the following information: _____ Intake Report
_____ Progress Notes
_____ Test Results
_____ Summary/Termination Report
_____ Telephone Consultation
_____ Correspondence to: _____
_____ Other: _____

The purpose and need for this disclosure is: _____

This consent may be ended at any time by the client, but ending the consent will not cancel any action that has already been taken as allowed by the form. Unless the client wishes to cancel this consent at an earlier time, it will automatically end upon the date and/or condition below:

- A. Date: _____
- B. Event/Condition: Termination of Sessions

It is understood that the duration of this consent will not be longer than would be necessary and reasonable to carry out the purpose for which it is given.

Date Signed

Signature of Client or Person
Authorized to Sign for Client

Date Witnessed

Witness Signature

NOTE TO THE PARTY OBTAINING INFORMATION

This information has been released from records whose confidentiality is protected by federal law which prohibits you from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose. (This form meets the requirements of Federal Regulation 42CFR. Part 2.)