Consent to Release and Obtain Confidential Information

Student Name: _____ ID #: _____ DOB: _____

I hereby consent and authorize **Cabrini University Counseling and Psychological Services** to ☑ release to ☑ obtain from:

Person(s)/Organization: _____

_____

I authorize the following types of information to be released:

__X__ WRITTEN INFORMATION. Copies of medical records to include medical and/or mental health treatment records to
the agency/person/persons listed above.

__X__ VERBAL INFORMATION. Verbal exchange of information to the agency/person/persons listed above.

This information will be released for the specific purpose of:

☑ Coordination of Services/Support □ Other:

_____

The information to be released is:

- ☐ Attendance
- ☐ Recommendations
- ☐ Psychological/Psychiatric Evaluations
- ☐ Other:
- ☐ Intake
- ☐ Summary of Treatment/Records
- ☐ Progress Notes

_____

Cabrini University Counseling and Psychological Services cannot guarantee the confidentiality of documents transmitted electronically or by Fax. Do you consent to information being sent electronically or by Fax? Yes __X__ No _____

This consent is valid for one calendar year from the date of signing unless otherwise noted, or revoked earlier.

Revoking the Authorization:
Consent may be revoked at any time by notifying Cabrini University Counseling and Psychological Services in writing. Revocation will not apply to information that has already been released in response to this authorization.

Photostatic copies of this form shall be considered valid.
The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

I have read this authorization and I understand and consent to it:

_____ _____

Signature of Client (or Person Authorized by Law) Date Signature of Witness
Date