Counseling Services Consent for Release of Information

PATIENT NAME: First and Last | Student ID#: | DOB: Month/Day/Year | AGE:

TELEPHONE#: | Emergency Contact Name: | Emergency Contact Ph#:

I hereby voluntarily request and authorize The University of Tampa Counseling Services to release/receive from

(Name/Title) (Agency Address) (Phone # y A wvm583.1(r

Speci c type of information to be disclosed:

- Assessment/evaluation/progress notes and treatment recommendation
- Release of full psychiatric records to the designated medical/psychiatric professional
- Diagnosis and/or medications
- Appointments attended/treatment dates

Purpose of Disclosure: _____

I understand that this information is protected under Federal con dentiality regulations and cannot be disclosed without my written notice to the counselor/practitioner. This authorization is in effect until graduation.

By signing below, I acknowledge that I have read and understand this authorization.

Signature of Patient or Guardian | Relation to Patient | Date: Month/Day/Year

Signature of HealthCare Provider | Printed Name/Title of Health Care Provider | Date: Month/Day/Year

Signature of Witness | Printed Name of Witness | Date: Month/Day/Year