CONCORDIA UNIVERSITY

Student Psychological Counseling Center
Authorization For Release of Information

Client Name: _____ Date of Birth: _____

Student ID: _____

I hereby authorize Concordia University Psychological Counseling Center

_____ **To release information to:**

_____ **To exchange information with:**

_____ **To request information from:**

Name of Person/Organization: _____

Address: _____

_____

Telephone Number: _( ) _____

Description of Information to be disclosed:
(NOTE: If mailing, send to Student Counseling Center, 1530 Concordia West, Irvine, CA 92612

_____ Psychotherapy: I authorize you to release information regarding:

____ progress to date ____summary of treatment

____ treatment plan ____dates of treatment

____ prognosis

____ provide a treatment summary including diagnosis and recommendations

_____Psychiatrist/ Physician I authorize you to provide all relevant treatment information to my counselor, including diagnosis and medication information.

_____Hospitalization I authorize you to provide a copy of psychological history, discharge summary, and results of psychological testing. Dates of hospitalization: _____

This information supplied is to be restricted to: _____

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 the Student Counseling Center in writing.

This authorization is valid from date of client signature to _____
If no date is indicated, this authorization will expire 12 months from date of signature.

Date: _____ Signature of Client: _____

Date: _____ Signature of Guardian/Parent:_____

Revised: 1/11