Furman University Counseling Center
Authorization for Release of Information

Name: _____ Furman ID# _____

Date of Birth: _____ Address _____

City: _____ State: _____ Zip: _____ Phone: _____

I authorize Furman University Counseling Center to release medical/mental health information to:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Type of disclosure authorized: ___ Verbal Report ___ Copies of Records ___ Letter ___ E-mail

Information to be released: ____ Mental Health Assessment ____ Progress Update

____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): _____

Expiration: Unless otherwise revoked, this authorization shall remain in effect until _____. If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed. This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to the Counseling Center. The revocation will take effect when the Counseling Center receives it, except to the extent that the Counseling Center or others have already taken action in reliance on this authorization.

Notice: The Counseling Center and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

_____ Date: _____
Signature of Patient

Witness: _____ Date: _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Rev. 10/10