Andrews University
Counseling & Testing Center

Authorization to Release/Exchange Confidential Information

In order to protect your right to confidentiality, your written authorization is required if you request information to be released to another person or agency. Counseling and Testing Center records are kept separate from your educational records for confidentiality purposes. However, information released to faculty and staff, for petitions, for recommendation for referrals or other such released information becomes the property of the recipient, and at the time, the Counseling and Testing Center cannot guarantee the confidentiality of those documents.

I _____ authorize _____ and other appropriate clinical staff members of the Counseling and Testing Center to:

❑ release to ❑ obtain from ❑ exchange with

the following:

Client's initial

_____ ❑ Residence Hall Dean
_____ ❑ Student Life Division
_____ ❑ University Medical Specialties
_____ ❑ Academic Dean
_____ ❑ Other _____

the following information pertaining to myself:

Client's initial		*Client's initial*	
_____	❑ assessment	_____	❑ testing results
_____	❑ attendance	_____	❑ recommendations
_____	❑ treatment progress	_____	❑ psychological records
_____	❑ treatment summary	_____	❑ psychiatric evaluation/ medical history
_____	❑ other _____		

for the purpose of:

❑ evaluation/assessment and/or coordinating treatment efforts

❑ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time by giving written notice (except to the extent that the information has already been released).

_____ _____
Signature of Client Date Signature of Staff Member Date

_____
Date of Birth

_____
Andrews ID

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