

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
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Specific 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 confidentiality 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
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Signature of HealthCare Provider	Printed Name/Title of Health Care Provider	Date: Month/Day/Year
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Signature of Witness	Printed Name of Witness	Date: Month/Day/Year
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