



*STUDENT COUNSELING SERVICES*

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**Request / Authorization for Release of Information**

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Client Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize and request that the following persons / agencies:

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

- Obtain** information contained in my clinical records **from** Regent University Student Counseling Services.
- Release** information contained in my clinical records **to** Regent University Student Counseling Services.  
(note: checking both boxes will allow for two-way communication between parties.)

The information to be released:

- |   |  |
|---|--|
| <input type="checkbox"/> Summary of treatment & recommendations | <input type="checkbox"/> Academic or educational records   |
| <input type="checkbox"/> Summary of assessment & diagnoses      | <input type="checkbox"/> Inpatient or outpatient treatment records                               |
| <input type="checkbox"/> History & physical                     | <input type="checkbox"/> Psychological / psychiatric / psychosocial history and/or evaluation(s) |
| <input type="checkbox"/> Discharge Summary                      |  |
| <input type="checkbox"/> Other: _____                           |  |

This consent may be canceled (revoked) at any time to the extent that the health care provider(s) named above or custodian of the records has not already taken action in the reliance upon it. This authorization will automatically expire in six (6) months from the date it is signed.

I hereby release the person or organization sending these records and results from any liability associated said release. I have read the above and acknowledge that I understand the terms and conditions of this authorization.

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian (if minor)

\_\_\_\_\_  
Signature of Parent/Guardian (if minor)

\_\_\_\_\_  
Date