DELTA STATE UNIVERSITY
Accessibility Services

CONSENT TO RELEASE INFORMATION

I, _____, hereby authorize the staff at Delta State University
(Individual or other authorized person completing this form)

Office of Health and Counseling and Accessibility Services to [check one]

☐ **exchange information with** ☐ **disclose information to** ☐ **receive information from**

Name: _____ **Phone #:** _____
(please print)

900 #: _____ **DOB:** _____
(month) (day) (year)

Contact Person(s) and/or Agency Name: _____

Address:

_____
(street) (city) (state) (zip)

Phone #: _____

The information to be disclosed is:
☐ Attendance information
☐ Summary of treatment
☐ Withdrawal/Readmission recommendation
☐ Other (specify): _____

The purpose of the disclosure is for:
☐ Further treatment
☐ Withdrawal/Readmission Process
☐ Other (specify): _____

This consent is effective on _____ and expires on _____. I understand that I may
(today's date) (no greater than 1 year)
revoke this consent <u>at any time</u> within the effective period by written request.

Authorized Person Signature: _____ Staff Name: _____

NOTICE: *This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. However, there are legal and ethical requirements that counselors take responsible action in those situation as prescribed by law 1) where there is danger of imminent harm to self or others, or 2) in the case of apparent child abuse.*