Consent for Release of Information

Weber State University
Counseling & Psychological Services Center
1114 University Circle
Ogden, UT 84408-1114
Phone: (801) 626-6406
Fax: (801) 626-6541

Client Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

W#: _____ **Phone Number:** _____

☐ **I authorize the Counseling and Psychological Services Center to release information to:**

_____
Name of Individual/Provider/Dept.

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

AND/OR

☐ **I authorize the Counseling and Psychological Services Center to obtain information from:**

_____
Name of Individual/Provider/Dept.

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

PURPOSE OF THIS RELEASE: _____

_____

_____

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:** _____

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans**

☐ **Treatment Summary** ☐ **Other: (**please describe) _____

I understand that the materials being released / requested are to be kept strictly confidential. Information may only be used for the above-stated purpose and no one other than the above parties has access to this information. I hereby acknowledge that this consent is voluntary and will expire automatically after 1 year from the date on which it is signed. I also understand that I may issue a written revocation of this permission at any time except to the extent that action based on this consent has already been taken.

Signature of Client or Representative: _____ Date: _____

Relationship to client (*if requester is not the client)*: ☐ Parent ☐ Legal Guardian ☐ Other: _____

Client or Representative has been provided a copy of this authorization: _____
Staff member providing copy

Rev 10/2005