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:**

AND/OR

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

Release to	Obtain from
______________________	______________________
Name of Individual/Provider/Dept.	Name of Individual/Provider/Dept.
______________________	______________________
Address	Address
______________________	______________________
City, State, Zip Code	City, State, Zip Code
______________________	______________________
Phone # Fax # (Include area code)	Phone # Fax # (Include area code)

PURPOSE OF THIS RELEASE: ______________________

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

☐ **Treatment Summary** ☐ **Assessments** ☐ **Laboratory Test Results**

☐ **Diagnosis/Diagnostic Impression/Symptoms** ☐ **Intake Summary/Progress Notes** ☐ **Treatment Plans**

☐ **Appointment History/Dates of Service** ☐ **Entire Psychiatric/Medical Record** ☐ **Discharge 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. I understand that I may request a copy of this authorization.

Signature of Client or Representative: ______________________ Date: ______________________

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

For Office Use Only

Date Records Received ______________

Directions for Office Staff:	Disposition:	Initials:
☐ Mail	Date Mailed______________	__________
☐ Fax	Date Faxed______________	__________
☐ Call Client for Pickup	Date Picked Up______________	__________
☐ Scan to File		

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