Frostburg State University
Counseling & Psychological Services
39 Cumberland Hall
Frostburg, MD 21532
Fax: 301.687.3065
Office: 301.687.4234

Authorization for the Release of Information

Legal Name: _____ Date of Birth: _____

Preferred Name: _____ Student ID #: _____

I, _____, hereby authorize the staff of Frostburg State University Counseling and Psychological Services in 39 Cumberland Hall, Frostburg, MD 21532 (phone number 301-687-4234) to:

[ ] disclose information to [ ] receive information from [ ] exchange information between

Name(s): _____
_____ **Phone #:** _____
Agency Name (if applicable):_____ **Fax #:** _____
Address: _____
_____

The specific information requested is:
___ Treatment Summary ___ Mental Health History ___ Physical Health History
___ Psychological Testing ___ Psychiatric Evaluation ___ List of Prescribed Medications
___ Attendance information ___Other (Specify)_____

For the purpose of:
___ Evaluation and Continuing Treatment ___ Referral ___ Confirmation of Attendance
___ Other (Specify) _____

I understand that my signature exempts the releasing agency from all legal liability that may arise from the disclosure of the information requested.

I further understand that I am authorizing the release of information from records whose confidentiality and privileged status is protected (under Title 42 of the Federal Code, "Family Educational Rights and Privacy Act of 1974") and that redisclosure of this information by the receiving agency is prohibited.

This authorization is for a ___ Single, or a ___Continuing Disclosure, valid for 365 days after the date of my signature as it appears below. I understand that I have the right to refuse to sign this authorization. If I agree to sign, I understand that I can revoke this authorization at any time.

Signature of Client: _____ Date: _____

Signature of Witness: _____ Date: _____