Frostburg State University
Student Counseling Center
118 Education & Health Sciences Center
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 Student Counseling Center in 118 Education & Health Sciences Center, 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: _______________