Request/Authorization to Release Confidential Records and Information

To:_____ Facility: _____

Address: _____

Phone: _____ Fax: _____

I, _____ hereby authorize you to release
(student name)
information from my clinical records to exchange information with the Disability Services Coordinator at Transylvania University. My date of birth is ____/____/____. The relevant information is to be used for the following purpose(s):

❏ Mental health evaluation ❏ Coordination of services ❏ Academic purposes ❏ Treatment Progress	❏ Compliance ❏ Title IX Investigation Other: _____ _____

- Items ***not to be released have a line drawn through them***.

Intake and discharge summaries Mental health evaluations/test results Developmental and/or social history Educational records	Medical history and evaluation Progress notes and treatment summary Other: _____ _____

- These records concern the approximate dates: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time, except to the extent that action based on this consent has already taken place. This consent will automatically expire after 12 months from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	____/____/____
Witness Signature	Printed Name	Date
_____	_____	____/____/____
Student Signature	Printed Name	Date
_____	_____	____/____/____
Guardian Signature (if applicable)	Printed Name	Date

Contact Information

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Phone: (859) 233-8502, Fax: (859) 233-8101.
Email: admorgan@transy.edu or disabilityservices@transy.edu