BRIGHAM YOUNG

UNIVERSITY

IDAHO

AUTHORIZATION FOR RELEASE OF COUNSELING INFORMATION

Notice: Confidential Counseling information generally cannot be released to others without your consent. Do not sign this release form unless it is completely filled out and you believe that the release of this information is in your best interests.

Name: _____ Date of Birth:_____/_____/_____

Address:_____ Phone: (_____)_____-_____

I do hereby authorize and direct _____ to

(Please check only one):

☐ Exchange information with ☐ Release information to ☐ Receive information from

Name: _____

Address: _____

Phone/Fax: _____

regarding myself, including, but not limited to, professional opinions, reports or examinations, tests, treatment, diagnosis, and prognosis pertaining to the following dates:

_____.

This authorization will expire in 120 days from the date signed.

I understand that I may revoke my authorization at any time by providing a written request for such, except as to actions that have been taken in reliance upon it. I also understand that a photocopy of this authorization may serve as an original.

Signed _____ Date _____

Witness _____