SYRACUSE UNIVERSITY COUNSELING CENTER

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ____ SU ID#___________________ DOB _____________,

hereby authorize a representative of the Syracuse University Counseling Center to seek information from and release information to:

Name of person, organization, or agency:____

Address:____

____

Phone: _________________________ **Fax**:_________________________

Extent or nature of the information to be disclosed (check all that apply):

Yes	No		Yes	No	
☐	☐	Attendance	☐	☐	Progress in Treatment
☐	☐	Treatment Plan	☐	☐	Recommendations
☐	☐	Substance Abuse Evaluation	☐	☐	Discharge Summary
☐	☐	_________________________			

Disclosure authorized for the following purposes (check all that apply):

☐ Confirmation of Attendance	☐ Referral
☐ Judicial/Legal Concerns	☐ Coordination of Treatment
☐ Confirmation of Progress	☐ ______________________________

I understand that the confidentiality of my patient records and other patient-identifying information will be respected, subject to applicable laws and regulation. I also understand that there are certain circumstances under which my right to confidentiality may be outweighed by a conflicting legal or ethical duty of the Counseling Center to disclose confidential information. This has been fully explained to me.

I may revoke this consent at any time, except to the extent that action has been taken by the Counseling Center in reliance on it. Unless I revoke my consent earlier in writing, this consent expires:

- ☐ 90 days after the date set forth below
- ☐ upon completion of the course of treatment to which records pertain
- ☐ 90 days after the treatment session
- ☐ ______________________________

☐ **I authorize this release to be faxed to the aforementioned person, organization or agency.**

The patient information to be released to and from the Syracuse University Counseling Center was fully explained to me, and this consent is given of my own free will.

Dated:______________________________

____
Signature of Patient

____
Signature of Parent or Guardian of Patient Under Age 18

____
Signature of Executor, Administrator, or Personal Representative, if Any, or Other Family Member of Deceased Patient