AUGUSTA UNIVERSITY
Student Counseling
& Psychological Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS

The purpose of this disclosure of information is to aid in assessment and treatment planning, for consultation and/or referral, and/or, when appropriate, to coordinate treatment services. I understand that my refusal to consent may prevent coordination of services and treatment.

I, _____, hereby authorize the Augusta University Student Counseling and Psychological Services staff, **to receive from and/or release** the following specific confidential information:

____ Confirmation that I have been a client of and/or received treatment, including session dates.
____ Summary Report of Counseling Assessment and Treatment
____ Other (specify):_____
_____

To ☐ **receive from:** ☐ **be released to:**

☐ AU Student Health Services, 1465 Laney-Walker Blvd, AF-1040 (Pavilion II), 706-721-3448

☐ AU CARE TEAM , 2500 Walton Way, Bellevue Hall 101, 706-737-1411

☐ AU Office of Testing & Disability Services, Summerville Campus, Galloway Hall, 706-737-1469

☐ Other: Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax #: _____

I understand that this authorization is valid for **12 months** after the date signed, unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying the Augusta University Student Counseling and Psychological Services in writing.

Signature of Client: _____Date_____

Signature of Student Counseling and Psychological Services Staff: _____Date_____