AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the University of North Florida Counseling Center located at 1 UNF Drive, Founders Hall, Bldg. 2, Room 2300, Jacksonville, FL 32224 (**phone: 904-620-2602**) (**fax: 904-620-1085**) to:

_X__disclose information regarding ______receive information regarding ____ exchange information regarding

____ To/From ____
Client Name Agency/Person Name

____ ____
Date of Birth Address

____ ____
N# City, State

____
Telephone

____
Fax

I understand the information to be disclosed includes mental health and/or psychiatric records, specifically;

[X] attendance information [X] summary of treatment [ ] med management records

[ ] Other (Specify): ____

The purpose of this disclosure is for: [ ] further treatment/continuation/coordination of care [X] facilitate academic progress

[ ] Other (specify): ____

This consent shall remain in effect for [X] 90 days [ ] 1 year [ ] other: ____________________________________

Notwithstanding the above noted time frames, this consent can be revoked at any time by notifying the UNF Counseling Center in writing. I hereby release the University of North Florida from any liability that may arise as a result of the use of the authorized information pursuant to this release.

I acknowledge that I have read this authorization and fully understand its contents.

____ ____
Signature of Client or Legal Guardian (if client is under 18) Date

Name (print)____

_____Self____
Relationship

PROHIBITION ON DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Any further disclosure is strictly prohibited (Reference 42 CFR Part 2) unless the client provides specific written consent for subsequent disclosure of this information. A COPY OF THIS DOCUMENT SHALL SERVE AS AN ORIGINAL. *O: Forms Revised 08/17*