

MEREDITH COLLEGE

Authorization Form

This form, when completed and signed by you, authorizes the Meredith College Counseling Center to release protected information from your clinical record to the person you designate below.

I, _____, authorize the Meredith College Counseling Center and/or the Center's administrative and clinical staff to release the following materials (provide a specific and detailed description of the information you want disclosed)

This information should only be released to

Name: _____

Address: _____

Phone/Fax: _____

By initialing this section I authorize the above named person to communicate with the Meredith College Counseling Center regarding me. _____

I am requesting the Meredith College Counseling Center to release this information for the following reasons: ("At the request of the individual" is all that is required if you are a client and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____ or until _____
(Fill in an event that relates to the individual or the purpose of the use or disclosure).

I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Meredith College Counseling Center. I understand that the Meredith College Counseling Center generally may not condition psychological services upon my signing an authorization. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information.

Signature of Client

Date

Signature of Witness / Counseling Center Staff

Date

If a personal representative of the client signs the authorization, a description of such representative's authority to act for the client must be provided.

COUNSELING CENTER

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Revised 8/1/07