



Authorization Form

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

I, _____, authorize the Meredith College Counseling Center/Disability Services 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/Disability Services 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/Disability Services. I understand that the Meredith College Counseling Center/Disability Services 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 Date

Student ID: _____

Signature of Witness, Counseling Center/Disability Services 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.