South Carolina State University
Office of Student Disability Services
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the release of below-identified information.
(Name of student/patient)

____ All Treatment Records	____ Psychiatric Consultation	____ Current Treatment Issues/Progress
____ Intake Assessment	____ Psychological Assessment	____ Diagnosis and Dates of Treatment
____ Case Notes	____ Medication Summary	____ Treatment and Discharge Summary

Other: _____

This information is to be:

___ released from SCSU to the indicated second party.

____ released to SCSU from the indicated second party.

___ exchanged between SCSU and the indicated second party.

___ I also authorize the information to be transmitted by EMAIL. **Student initials: _____**

Second party: Name: _____
Address: _____

Phone: _____

This information is to be released for the following purpose:

Treatment Planning _____ Treatment Coordination _____ Facilitation of Referral _____

Other: _____

I authorize the release of information for the following dates: ___ All dates of contact,

____ Other (specify date or date range): _____

This authorization of release pertains only to the above-specified information and to the above-specified parties. I also understand that I may revoke this authorization at any time in writing except to the extent that SCSU has already taken actions in reliance on it, and that the authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

_____ _____
Student Signature **Date**