Clear Form

DELTA STATE UNIVERSITY
Disability Services

CONSENT TO RELEASE INFORMATION

I, _____, hereby authorize the staff at Delta State University
(Individual or other authorized person completing this form)

Office of Health and Counseling and Disability Services to [check one]

☐ **exchange information with** ☐ **disclose information to** ☐ **receive information from**

Name: _____ **Phone #:** _____
(please print)

900 #: _____ **DOB:** _____
(month) (day) (year)

Contact Person(s) and/or Agency Name: _____

Address:

_____
(street) (city) (state) (zip)

Phone #: _____

The information to be disclosed is:
☐ Attendance information
☐ Summary of treatment
☐ Withdrawal/Readmission recommendation
☐ Other (specify): _____

The purpose of the disclosure is for:
☐ Further treatment
☐ Withdrawal/Readmission Process

☐ Other (specify):

This consent is effective on _____ **and expires on** _____. **I understand that I may**
(today's date) (no greater than 1 year)
revoke this consent <u>at any time</u> within the effective period by written request.

Authorized Person Signature: _____ **Staff Name:** _____

NOTICE: *This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. However, there are legal and ethical requirements that counselors take responsible action in those situation as prescribed by law 1) where there is danger of imminent harm to self or others, or 2) in the case of apparent child abuse.*

▪ *Delta State University* ▪ *Office of Health and Counseling*
O.W. Reily Student Health Center ▪ *Cleveland, MS 38733* ▪ *Phone: (662) 846-4630*
Email: ADA@deltastate.edu ▪ *Website: www.deltastate.edu*

Send to

Print form