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ARIZONA STATE UNIVERSITY

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ASU Counseling Services

CONSENT TO RELEASE CLINICAL INFORMATION

NAME: _____ **DOB:** _____ **ASU ID:** _____

I, the undersigned, hereby authorize **ASU Counseling Services** to release/exchange information concerning the above-named person to:

_____	_____
Name of Person or Institution	**Work Phone Number**
_____	_____
Address	**Home Phone Number**
_____	_____
City **State** **Zip**	**Cell Phone Number**

Specific type of information to be disclosed/exchanged:

- ❑ Assessment
- ❑ Attendance
- ❑ Treatment progress
- ❑ Testing reports
- ❑ Substance use/abuse
- ❑ Case records
- ❑ Treatment summary
- ❑ Lab test results
- ❑ Psychiatric evaluation
- ❑ Medication information
- ❑ Recommendations
- ❑ Diagnosis
- ❑ Other _____
- ❑ All of the above

I understand that the information is to be used for:

- ❑ Academic considerations
- ❑ Aftercare planning
- ❑ Continuity of treatment
- ❑ Coordination of treatment
- ❑ Family involvement
- ❑ Other _____

As the person signing this consent, I understand that (1) I am giving permission for disclosure of confidential mental health and health care information and records, (2) I have the right to revoke this consent by delivering a written request to the person or agency who is in possession of my original records (my decision to revoke my consent will not affect information released before the written request is received), and (3) **the person or agency who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. ASU Counseling Services cannot guarantee that the recipient of these records will not re-disclose records**. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. This consent extends to all records, including those records that may relate to HIV, sexually transmitted disease, and substance abuse.

This release expires in 12 months unless another date is specified: _____

Name: _____
Signature

Name: _____
Print **Date**

Address: _____
Street or Box

_____
City **State** **Zip**

Phone: (___)_____

Witness: _____ **Identity of authorized**
Signature **Date**

Revised 12/04/22