AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the University of North Florida Counseling Center located at 1 UNF Drive, Founders Hall, Bldg. 2, Room 2300, Jacksonville, FL 32224 (phone: 904-620-2602) (fax: 904-620-1085) to:

_X_ disclose information regarding _____ receive information regarding ____ exchange information regarding

	To/From	
_____ Client Name		_____ Agency/Person Name
_____ Date of Birth		_____ Address
_____ N#		_____ City, State
		_____ Telephone
		_____ Fax

I understand the information to be disclosed includes mental health and/or psychiatric records, specifically;

[X] attendance information [X] summary of treatment [ ] med management records

[ ] Other (Specify): _____

The purpose of this disclosure is for: [ ] further treatment/continuation/coordination of care [X] facilitate academic progress

[ ] Other (specify): _____

This consent shall remain in effect for [X] 90 days [ ] 1 year [ ] other: _____

Notwithstanding the above noted time frames, this consent can be revoked at any time by notifying the UNF Counseling Center in writing. I hereby release the University of North Florida from any liability