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 23 Jacksonville, FL 32224 phone: 904-620-2602 (fax: 904-620-1085) to:

__X__ disclose information regarding _____ receive information regarding ___ exchange information regarding

_____	To/From Dean of Students
Client Name	Agency/Person Name
_____	1 UNF Drive, Bldg. 57 Suite 2700
Date of Birth	Address
_____	Jacksonville, FL
N#	City, State
	(904) 620-1491
	Telephone
	(904) 620-3922
	Fax

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

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

[ ] Other (Specify): _____

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

[X] Other (specify) Medical Withdrawal/Support Letter

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

Notwithstanding the above noted time, 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 that may arise as a result of the use of the authorized information pursuant to this release.

I acknowledge that I have read this authorization and fully understand its contents.

_____ _____

Signature of Client or Legal Guardian (if client is under 18) Date

Name (print) _____

__self_____

Relationship

PROHIBITION ON DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Any further disclosure is strictly prohibited (Reference 42 CFR Part 2) unless the client provides specific consent for subsequent disclosures of this information. A COPY OF THIS DOCUMENT SHALL SERVE AS AN ORIGINAL.