Brandeis Counseling Center
Mailstop 061, P.O. Box 549110
Waltham, MA 02454-9110
Phone (781) 736-3730 Fax (781) 736-3731

Authorization for Release of Information

Student Information

Name_____ Student ID#_____
Date of Birth_____ Phone _____
Address_____
City_____ State_____ Zip Code_____

RELEASE INFORMATION TO:

I authorize Brandeis University Counseling Center to release my information to the following individual/healthcare provider:
Name:_____ Title:_____
Address:_____
City_____ State_____ Zip Code_____
Phone:_____ Fax:_____
Method of disclosure:
Fax ____ Mail____ Verbal___

OBTAIN INFORMATION FROM:

I authorize the care provider listed below to release my information to the Brandeis University Counseling Center:
Name:_____ Title:_____
Address:_____
City_____ State_____ Zip Code_____
Phone:_____ Fax:_____
Brandeis University Psychological Counseling Center staff obtaining information:_____

Comments/Notes/Specific Information Requested:_____

I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclosure of the above information about, or medical records of, my condition to or from those persons or agencies listed above. I further release Brandeis University from any liability arising from said release of information if done substantially in accordance with applicable law.

I understand that all information is confidential and my records are protected under law and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, expect to the extent that action has already been taken to comply with it. Without my expressed revocation, this authorization will automatically expire:

____ After ninety (90) days from the date of signing ____ Other:_____

_____ _____
Signature of student or parent of minor Date

_____ _____
Signature of witness Date