

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 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, except 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