

APPENDIX H

Cumberland University Counseling Center  
One Cumberland Square  
Lebanon, TN 37087  
(615) 547-1397

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**Authorization for Release of Information**

Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

By signing below, I hereby authorize \_\_\_\_\_ of  
Cumberland University Counseling Center to exchange the following information with:

Name: \_\_\_\_\_  
Of: \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

_____ Initial evaluation	_____ Prescribed medications
_____ Progress in counseling	_____ Medical evaluation
_____ Progress notes	_____ Confidential HIV information
_____ Consultation Reports	_____ Alcohol and substance abuse
_____ Psychological tests and assessments	_____ Discharge/Treatment Summary
_____ Psychiatric evaluation	_____ Other: _____

Limitations, if any:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that this information will be exchanged to provide quality care and to better coordinate services. I understand that I may revoke this consent at any time by notifying the parties involved in writing. I sign this form voluntarily and understand that this authorization will automatically expire one year from this date. If I choose not to sign this authorization, I understand that my refusal to sign this form will result in the information NOT being exchanged unless required by law or a substantial threat is posed to myself or others and that this may have an impact on the continuity of my care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_