APPENDIX H

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

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
_____Progress in counseling
_____Progress notes
_____Consultation Reports
_____Psychological tests and assessments
_____Psychiatric evaluation
_____Prescribed medications
_____Medical evaluation
_____Confidential HIV information
_____Alcohol and substance abuse
_____Discharge/Treatment Summary
_____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: _____