

### CONSENT FOR RELEASE OF INFORMATION

\_\_\_\_\_  
(Client's full name)

\_\_\_\_\_  
(Client's Date of Birth)

I hereby authorize Counseling & Wellness Center to disclose and/or exchange information in the form of record copies and professional communications (written and/or oral) to/with the following person or agency:

\_\_\_\_\_  
(Name of person and/or agency)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone)

Specific information to be disclosed: Check all that apply:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Attendance              | <input type="checkbox"/> Progress Notes   | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Safety Concerns         | <input type="checkbox"/> Intake Summaries | <input type="checkbox"/> Evaluations     |
| <input type="checkbox"/> Academic Related Issues | <input type="checkbox"/> Diagnosis        |  |
| <input type="checkbox"/> Treatment Summary       | <input type="checkbox"/> Closing Summary  |  |
| <input type="checkbox"/> Other (specify) _____   |   |  |

The disclosure/exchange is requested for the purpose of: Check all that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Coordination of Care         | <input type="checkbox"/> Transfer of Care                                       |
| <input type="checkbox"/> Letter of Support            | <input type="checkbox"/> Advocacy   |
| <input type="checkbox"/> To address Academic Concerns | <input type="checkbox"/> Other (specify) <u>Student academic accommodations</u> |

I acknowledge that I have been informed of my rights as a client and I have read and signed the Consent for Treatment. I understand that I have the right to inspect and copy the information to be disclosed. My consent is given from the signature date of this document through:

\_\_\_\_\_  
(Allow at least six months)

I understand that I have the right to revoke this consent in writing at any time. I understand and agree that revocation of this consent must be communicated to the Counseling & Wellness Center. It has been explained to me that if I refuse to consent to this release of information, or I revoke my consent in writing, no information will be shared.

\_\_\_\_\_ 



Counseling & Wellness Center  
GSU4U Program  
A Building, A1120  
University Park, IL 60484  
708-235-7334  
[www.govst.edu/gsu4u](http://www.govst.edu/gsu4u)

(Date)

(Signature of client)

\_\_\_\_\_

(Print name)

\_\_\_\_\_

(Address)

\_\_\_\_\_

(Phone number)

\_\_\_\_\_  
(Signature of witness)

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (IL. Rev. Stat., ch. 91 1/2, par. 801 et seq.) you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure. 4/2018