



Counseling Services, Student Affairs Division
 3001 Mercer University Drive
 Atlanta, Georgia 30341
 (678) 547-6060 • FAX (678) 547-6054

REQUEST /AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I _____ hereby authorize Mercer University Counseling Services
 (Name of Student/Client)

to release/exchange information pertaining to myself to:

Person or facility: _____

Address: _____

Phone: _____ FAX: _____

I understand the information is to be used for:

- Further mental health evaluation, treatment, or care
- Verbal consultation of client's issues between authorized individuals
- Treatment planning
- Other: _____

These records concern time between _____ and _____

Information to be disclosed/exchanged:

- Record of attendance
- Intake and discharge summaries
- Medical history and evaluation(s)
- Mental health evaluation(s)
- Developmental and/or social history
- Educational records
- Progress notes and treatment or closing summary
- Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: Do not release.

This **Request/Authorization to Release Records and Information** form was explained and fully understood by me, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

 Signature of Client Printed Name Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent but was physically unable to provide a signature.

 Signature of Client's Witness Printed name Date