



AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the University of North Florida Counseling Center located at 1 UNF Drive, Founders Hall, Bldg. 2, Room 2300, Jacksonville, FL 32224 (phone: 904-620-2602) (fax: 904-620-1085) to:

disclose information regarding     receive information regarding     exchange information regarding

Client Name	To/From	Agency/Person Name
Date of Birth		Address
N#		City, State
		Telephone
		Fax

I understand the information to be disclosed includes mental health and/or psychiatric records, specifically;

attendance information     summary of treatment     med management records

Other (Specify): \_\_\_\_\_

The purpose of this disclosure is for:     further treatment/continuation/coordination of care     facilitate academic progress

Other (specify): \_\_\_\_\_

This consent shall remain in effect for  90 days     1 year     other: \_\_\_\_\_

Notwithstanding the above noted time frames, this consent can be revoked at any time by notifying the UNF Counseling Center in writing. I hereby release the University of North Florida from any liability