CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (Name), give full permission

to: **York College Counseling Services**
York, PA 17403-3651
Phone: (717)-815-1787 Fax: (717)-849-1627

To exchange information on: _____ DOB: _____
(Students Name)

By means of: ____ telephone ____in writing/fax ___in person

To release information to:

Name: _____
Address: _____
City/St/Zip: _____
Phone: ( ) _____
Fax: ( ) _____

To receive information from:

Name: _____
Address: _____
City/St/Zip: _____
Phone: ( ) _____
Fax: ( ) _____

INFORMATION REQUESTED:

_____ PRESENCE IN TREATMENT
_____ EVALUATION INFORMATION
_____ DIAGNOSIS
_____ TREATMENT SUMMARY
_____ TREATMENT PLAN
_____ TYPE OF TREATMENT
_____ NUMBER OF SESSIONS
_____ RESPONSE TO TREATMENT
_____ CRISIS INTERVENTION OR ASSESSMENT
_____ DISCHARGE SUMMARY
_____ FOLLOW-UP RECOMMENDATIONS
_____ MEDICAL HISTORY
_____ CURRENT MEDICATIONS
_____ PSYCHOLOGICAL TESTING
_____ PSYCHIATRIC EVALUATION
_____ TRANSFER OF SERVICES
_____ REFERRAL TO ADJUNCT RESOURCES

THE PURPOSE OR NEED FOR SUCH DISCLOSURE:

_____TO AID IN TREATMENT STRUCTURE
_____FOR THE PURPOSE OF ADMINISTRATIVE/ACADEMIC PLANNING
_____OTHER: _____

I understand that these records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent. Information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I also understand that I can revoke this consent at any time in writing, except to the extent that the person who is to make the disclosure or the person receiving the information has already acted upon it. I understand that this consent expires automatically as described below. I understand that I may request further explanation of this form at any time. I understand that I can receive a copy of this form upon my request.

I understand the content of this form as it has been explained to me.

The authorization of this form is valid until _____ unless revoked in writing prior to the expiration date. This authorization and request is fully understood and voluntary on my part.

Signature _____ **Date**_____

Name (Print) _____

Address and Telephone Number _____

Signature of witness _____ **Date** _____