RELEASE OF INFORMATION

I,_____, hereby voluntarily authorize:

Cal Poly Counseling Services
Building 27, Room 136, San Luis Obispo, CA 93407
(805) 756-2511 FAX (805) 756-6525

to exchange information with: ***the records of:***

(Name)_____ *(Name)_____*

(Agency)_____ *(UID#)_____*

(Address)_____ *(Address)_____*

(City/State)_____ *(City/State)_____*

(Telephone)_____ *(Telephone)_____*

(FAX)_____

This release is for the purpose of:

_____

By signing this document, I consent to release of my counseling and other medical records, and understand and accept all consequences related to their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time. I understand that information used or disclosed under this authorization may be subject to redisclosure by the recipient. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above, whichever occurs first.

THIS RELEASE OF INFORMATION IS VALID FOR INFORMATION TRANSFER FOR ONE (1) YEAR OR UNTIL _____(DATE), WHICHEVER OCCURS FIRST.

_____ _____ _____
Signature of Client *Printed Name* *Date*

_____ _____ _____ _____
Signature of Parent/ Guardian/Representative *Printed Name* *Relationship* *Date*
(for minors under 18 only)

white copy-Counseling Services *yellow copy-consultant* *pink copy-student*