COUNSELING SERVICES

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

Student's Name ______________________ Date of Birth ________________

I, ________________________ and/or ______________________________
(name of parent or guardian)

hereby authorize and request that; ___________________________________
(counselor's name)

may release or obtain (circle one) the following confidential information pertaining to me (or my minor children).

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to: _________________________________

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I understand that I may revoke this consent at any time by informing the above parties in writing.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature ____________________________ Date _____________________
(student)

and/or

Signature ____________________________ Date _____________________
(Parent/Guardian)