the counseling center
OF UAHUNTSVILLE

136 Madison Hall
Huntsville, AL 35899
T 256.824.6203 F 256.824.6672
www.uah.edu/counseling

AUTHORIZATION FOR THE RELEASE OF INFORMATION

CLIENT INFORMATION

Client name: _____ SSN#: _____

Address: _____

Home phone: _____ Cell phone: _____ Date of birth:_____

RELEASE

I, _____ authorize the UAHuntsville Counseling Center
(Client Name—Please Print)

to RELEASE TO/OBTAIN FROM:

Name:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Type of information to be released:

☐ Verbal communication ☐ Written communication ☐ Dates of attendance in treatment

☐ Compliance with treatment ☐ Clinical summary ☐ Recommendations

☐ Other (please specify):_____

AGREEMENT

- I understand that the release of information is limited to the party named above and that it will not be passed on to anyone else or used for any other purpose other than that specified below.
- I understand that I may cancel this authorization by providing written revocation to UAHuntsville Counseling Center.
- I understand that cancellation does not affect prior action taken under this authorization.
- I understand that a photocopy of this authorization is as authentic as the original signed authorization for release of information.
- I understand authorization expires in one year from the date of this authorization.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

This information has been disclosed to you from records whose confidentiality may be protected by federal and state law. If the records are so protected, you are prohibited from making any further disclosure without the specific written consent of the person to whom it pertains, or may result in civil damages and/or criminal penalties.