CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

UNIVERSITY COUNSELLING SERVICE
THE UNIVERSITY OF THE WEST INDIES, MONA

I, _____, (ID #: _____)

authorize the University Counselling Service to

☐ release to: ☐ obtain from: ☐ exchange with:

Name: _____

Title: _____

Address/Organisation:_____

Telephone Number(s):_____

E-mail Address: _____

Information relating to me as follows:

☐ treatment summary ☐ history/intake

☐ diagnosis ☐ psychological test results

☐ psychiatric evaluation/medication history ☐ dates of treatment attendance

☐ other (specify) _____

For the purpose of:

☐ evaluation/assessment and/or co-ordinating treatment efforts

☐ other (specify) _____

I understand that authorization shall remain valid for one year from the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may issue a written revocation of my consent at any time (except to the extent that the information has already been released).

_____ _____

Signature of Client Date of Authorization

_____ _____

Signature of Witness Date