PERMISSION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the Counseling and Psychological Services staff of Stevens Institute of Technology located in 1 Castle Point Terrace, Howe Center 7th Floor, Hoboken, NJ 07030 (phone: 201-216-5177) to:

[ ] disclose information to **[ ] receive information from** **[ ] exchange information with**

(1) Name(s) _____ **Agency Name** _____

Address _____ **Phone** (_____)_____-_____
(street) (city) (state) (zip)

(2) Name(s) _____ **Agency Name** _____

Address _____ **Phone** (_____)_____-_____
(street) (city) (state) (zip)

(3) Name(s) _____ **Agency Name** _____

Address _____ **Phone** (_____)_____-_____
(street) (city) (state) (zip)

Regarding _____ **Client Phone (**_____)_____-_____
(Client Name – please print)

Client Address: _____
(street) (city) (state) (zip)

DOB: _____ **SS#:** _____

The information to be disclosed is:
[ ] Attendance information / Dates of Attendance
[ ] Summary of treatment
[ ] All treatment records
[ ] Withdrawal / Readmission recommendation
[ ] Other (specify) _____

The purpose of this disclosure is for:
[ ] Further treatment
[ ] Letter of support
[ ] Withdrawal / Readmission process
[ ] Other (specify)
_____

This consent is effective on _____ **and expires on**_____.

I understand that I may revoke this consent <u>at any time</u> by giving written notice to the person or organization making this disclosure.

Client Signature: _____ **Name of CAPS Therapist:** _____

NOTICE: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. (However, there are legal and ethical requirements that counselors take responsible action in those situations as prescribed by law 1) where there is danger of imminent harm to self or others, 2) in case of emergent hospitalization, and (3) in the case of apparent abuse of a vulnerable party.