SHAW UNIVERSITY 1865 | Counseling Center

Authorization Release Form

Treatment/service date(s) for requested information: _____

I acknowledge that the information to be released MAY INCLUDE information protected by law. My initials below authorize inclusion of information pertaining to:

____ Mental Health _____ Substance Abuse _____ HIV/Other Reportable STIs ____N/A

I understand that:

1. I must notify Shaw University of my discharge immediately.
2. I must disclose my discharge documents to counseling center and health center immediately following discharge.
3. Immediately following discharge I must contact Shaw Counseling Center and disclose medical assessments, as well as attend a follow- up assessment with Shaw Campus Health Center in order to evaluate readmission to classes.

I have been informed and understand that information disclosed pertinent to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this Authorization form

_____ Signature of Patient

_____ Printed Name of Patient

_____ Date

OR if patient is under the age of 18

_____ Signature of Guardian

_____ Printed Name of Guardian

_____ Date

Forward Completed Form To:

Shaw University
Counseling Center
118 E. South Street Raleigh, NC 27601
Fax: (919) 821-8403
Email: jcarver@shawu.edu