

COUNSELING CENTER

PERMISSION FOR RELEASE OF INFORMATION

I,					
Counseling Center staff of Shaw U	University located	d 118 E. South St	reet Raleigh, NC	27601 to:	
() Disclose Information To ()	Receive Informa	tion From ()	Exchange Inform	ation With	
Name(s):		Phone#:			
Name or Agency Name:					
Address:					
(Street)		(City)	(State)	(Zip)	
Regarding:	Client Phone:				
Client Address:					
(Street/ Dormitor	ry Building)	(City)	(State)	(Zip)	
Classification:	Student ID#:		Age:		
Attendance Information Summary Of Treatment All Treatment Records Withdrawal/ Readmission Reco Other (Specify)					
The purpose of this disclosure is f Further Treatment Withdrawal/ Readmission proce Supervision Other (Specify)	ess				
This consent is effective on		and expires	on		
	(Date)		(Date)		
I understand that I may revoke thi person or organization making thi		NY TIME by give	ing written notice	to the	
Client Signature:	The	rapist Name:			
NOTICE: This information has be	een disclosed fro	m confidential re	cords. Any furthe	r disclosure	

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, and 2) in the case of apparent child abuse.)