STATE UNIVERSITY OF NEW YORK AT FREDONIA
CONSENT TO RELEASE & RECEIVE CONFIDENTIAL INFORMATION

Fredonia ID # _____

I,_____,_____(**DOB**), hereby authorize that information regarding myself, which may include personal, psychological, psychiatric and medical records and opinions, be both released and received by:

Name: **Student Health Center**

Address: **State University of New York at Fredonia**

_____

and
The Counseling Center
State University of New York at Fredonia
Fredonia, New York 14063
T: (716) 673-3424
F: (716) 673-3140

The specific information to be exchanged is as follows:

_____

Medical and mental health records

_____

_____

The purpose of releasing this information is for: **Coordination of Services**

_____

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire automatically after 365 days from the date on which it is signed or for the duration of counseling services.

In consideration of this consent, I hereby release the above parties from any and all liability arising therefrom. A photocopy of this release is to be considered as valid as the original.

_____ _____
(Signature of client or guardian) *(Date)*

_____ _____
(Signature of witness) *(Date)*

Client name (printed): _____