CONSENT FORM
OF
RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (Student Name), **authorize Andrews University:**

Counseling & Testing Center

Medical Specialties

Faculty/Staff

Other:_____

To disclose to referring Faculty/Staff/Department/USIT, the following information, by written or verbal communication:

Attendance to mandated treatment/appointments

Recommendations for treatment

Test results

Other:_____

For the Purpose of: [ ] Compliance with attendance [ ] other: _____

I understand that my records are protected under the code of Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below. **Date, event, or condition upon which this consent expires:**

End of school year **End of semester**

Other: _____

Student: _____ **Date:** _____
Signature

Witness: _____ **Date:** _____
Print