Shepherd University Student Health Services
Gardiner Hall –Ground Floor
Shepherdstown, WV 25443
Ph:304-876-5161 fx:304-876-5509

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of client (self):_____

Birth Date: _____

I _____, give permission to Shepherd University

___Release information to

___Exchange information with

___Obtain information from

_____**FAX**_____
(Name of Entity)

for the purpose of_____

Information is limited to (please check/initial)

__No limitations

__Evaluation/Intake summary

__Lab reports

__Progress notes

__Progress summary

__Psychological report (example: depression screening)

__Substance abuse (if checked, please see addendum)

__Verbal exchange of information

__Other

I understand that my records are protected under state and federal 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.

Signature of client: _____ Date: _____

Signature of witness: _____ Date: _____