ST. CLOUD STATE UNIVERSITY

DEPARTMENT OF COMMUNITY PSYCHOLOGY,
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INFORMED CONSENT

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize the Graduate Student Counselor trainee _____ to:
(PRINT YOUR NAME) (PRINT TRAINEE'S NAME)

- ☐ release to:
- ☐ obtain from:
- ☐ exchange with:

_____
_____
_____
_____
(Please specify the individuals or entities)

the following information pertaining to myself:

- ☐ treatment summary
- ☐ history/intake
- ☐ diagnosis
- ☐ psychological test results
- ☐ psychiatric evaluation/medication history
- ☐ dates of treatment attendance
- ☐ other (specify) _____

for the purpose of:

- ☐ evaluation/assessment and/or coordinating treatment efforts
- ☐ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

_____
_____
(Please specify the conditions that will restrict or extent this authorization)

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time **in writing** (except to the extent that the information has already been released).

_____ Date of Birth: _____
Signature of Client Date

_____
Signature of Witness Date