

## CONSENT FOR RELEASE OF INFORMATION

I understand that my treatment and educational records are confidential and cannot be disclosed except as authorized by this or any other release signed by me, or as provided by law.

I hereby consent to the release of that information by those specified below:

1. by: (Name of therapist, attorney....etc)

to: Randi Darnall Burke, Dean of Students  
Christine Mata, Associate Dean of Students  
Vincent Feliz, CARE Services Coordinator

2. by: Randi Darnall Burke, Dean of Students  
Christine Mata, Associate Dean of Students  
Vincent Feliz, CARE Services Coordinator

to:

This consent will expire on \_\_\_\_\_, or at such earlier time as I revoke it in writing to the indicated parties.

Student/Client Signature: \_\_\_\_\_

Student/Client Printed name: \_\_\_\_\_

Date Signed: \_\_\_\_\_