Nicholls State
University Counseling Center
P.O. Box 2067
Thibodaux, LA 70310
985.448.4080
Fax 985.448.4890

Name_____
Date_____
Student or Employee ID#_____
Date of Birth_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____hereby
client's signature
authorize_____, of the Nicholls State University Counseling Center

_____ to OBTAIN from _____
Name of Person or Agency

_____ to RELEASE to

_____ to MAKE TELEPHONE CONTACT with _____
Address

_____ to CORRESPOND with _____
by phone, email, via fax, etc. City, State, Zip Code

_____
Telephone Number

a copy of the following

_____ Medical/Psychiatric Records

_____ Psychotherapy evaluation/treatment records

_____ Discharge summary and Diagnoses

_____Verification of attendance

_____ Other (please specify):_____

for the purposes of _____

_____

All information I hereby authorize to be obtained from the agency will be held strictly confidential and cannot be released by the recipient without my written consent. It is further understood that information released is for professional purposes only and may not be provided in whole or part to any other agency, organization, or person other than stated above. I also understand and consent that this information may be sent via facsimile transmission. I understand that this authorization will remain in affect for:

_____ ninety (90) days, unless I specify an earlier expiration date_____
Date

_____ one (1) year

_____ the period necessary to complete all transactions on matters related to services provided to me

_____ _____
Date Signature of Client

_____ _____
Date Signature of Witness