Syracuse University

Counseling Release of Information Request Form

Please complete the following and return by mail to Barnes Center at The Arch, Attn: Counseling, 150 Sims Drive, Ste. 302, Syracuse, NY 13244, or by fax to 315.443.4276.

- Full name of student:
- Student's date of birth:
- Student's SU I.D. Number:

I, _____, hereby authorize a representative of the Syracuse University Barnes Center at The Arch Counseling team to seek information from and release information to the following.

- Name of person, organization or agency:
- Address of person, organization or agency:
- Phone number of person, organization or agency:
- Fax number of person, organization or agency:

Extent or nature of the information to be disclosed (check all that apply).

- ☐ Attendance
- ☐ Discharge Summary
- ☐ Progress in Treatment
- ☐ Recommendations
- ☐ Substance Abuse Evaluation
- ☐ Treatment Plan
- ☐ Other:

Disclosure authorized for the following purposes (check all that apply).

- ☐ Confirmation of Attendance
- ☐ Confirmation of Progress
- ☐ Coordination of Treatment
- ☐ Judicial/Legal Concerns
- ☐ Referral
- ☐ Other:

Unless I revoke my consent earlier in writing, this consent expires:

- ☐ 90 days after the date set forth below.
- ☐ 90 days after the treatment session.
- ☐ Upon completion of the course of treatment to which records pertain.

I authorize this release to be faxed to the aforementioned person, organization or agency.

- ☐ Yes
- ☐ No

The patient information to be released to and from the Barnes Center at The Arch Counseling team was fully explained to me, and this consent is given of my own free will.

- Date:
- Signature of patient:
- Signature of parent or guardian of patient under age 18:
- Signature of executor, administrator or personal representative, if any, or other family member of deceased patient: