CONFIDENTIAL VOLUNTARY REFERRAL

Name of Student ______________________ AU ID# ______________Phone # ______________

Referred by: USIT Division of Student Life Dean Faculty Staff

Referring Professional: ____Phone# ______________
First Name Last Name

CONSENT FORM
OF
RELEASE OF CONFIDENTIAL INFORMATION

Optional:

The above named student has explored with me his/her need for counseling, understands the benefits of counseling, and is open to engaging in a psychotherapeutic experience.

TO BE COMPLETED BY STUDENT

Purpose: To help me develop skills needed to succeed at Andrews University and beyond

I, ________________________________ (Student Name), **authorize Andrews University:**

Circle One: Counseling & Testing Center / Medical Specialties / Faculty/Staff

Other:____

To disclose to referring Faculty/Staff/Department/USIT, the following information, by written or verbal communication:

Attendance to appointments

I understand that my records are protected under the code of Federal Confidentiality 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 (e.g. probation, parole, etc.) and that in any event this consent expires automatically as described below. **Date, event, or condition upon which this consent expires:**

End of school year **End of semester**