NC STATE UNIVERSITY

NC State Counseling Center
Division of Academic and Student Affairs

http://counseling.dasa.ncsu.edu

Student Health Center, 2nd Floor
2815 Cates Avenue
Campus Box 7312
Raleigh, NC 27695-7312

P: 919.515.2423
F: 919.515.8525

COUNSELING INFORMATION RELEASE

Name: _____
Address: _____
Student ID#: _____ Phone Number: _____ DOB: _____
I hereby authorize _____ To: ☐ exchange ☐ release ☐ obtain
the following information with/to: _____
Address: _____
Phone: _____ Fax: _____
For the purpose of: ☐ treatment/progress/continuity of care **OR** ☐ _____(specify)
INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

___ Dates of Service/Treatment
___ Summary of Counseling and Psychological Services
___ Summary of Psychiatric Evaluations and Services
___ Medications Prescribed
___ Substance Use Treatment (if applicable)
___ HIV/AIDS/ARC Related Information (if applicable)
___ Related to (specify): _____

Notice to party receiving alcohol/drug use information (if applicable): This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

In authorizing the release of counseling information, I am aware that records may contain: psychiatric, mental health, substance use/treatment, HIV/AIDS status, or other confidential information that I may deem sensitive. I understand that alcohol/drug treatment records are protected under Federal regulations 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. If unsure of the contents of your counseling record request an appointment with a counselor to discuss this prior to authorizing release.

I agree that a copy, fax, or electronic copy of this release shall be as valid as this original release. Unless specifically requested in writing that the disclosure be made in a certain format, the Counseling Center reserves the right to disclose information permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to, verbally, paper format, or electronically. Further, I realize there are inherent risk in faxing or electronically sending records. This release is valid for 1 year and is subject to writing revocation at any time by me, except to the extent that action has been taken in reliance on the authorization. I will not be denied services if I refuse to consent to a disclosure for purpose other than as necessary for treatment, payment or health care operations, by law. If student is under age 18 parent/guardian must also sign release of information. A copy of this authorization will be provided upon request.

Signature: _____ Date: _____

Witness
Signature: _____ Date: _____