



Counseling Services

Authorization for Release of Information & Records

I authorize and request of Madison College Counseling Services to: Release to Obtain from

Individual Phone Number

Agency Fax Number

Address Email

City State Zip Code Relationship to Client

The following information from the record of:

Client Name Social Security#

Phone Number or Date of Birth

Pertaining to:

- Academic Performance
- Career/Vocational Counseling
- Personal Counseling
- Alcohol or Other Drug Abuse
- Psychiatric Evaluations
- Educational Records
- Psychological Evaluations
- Other

This information will be used for:

This authorization is in effect from until unless revoked in writing by me.

Client Signature

Date

Staff Witness Signature

Date