The University Of
TAMPA
DICKEY HEALTH AND WELLNESS CENTER

Counseling Services Consent for Release of Information

PATIENT NAME: First and Last | **Student ID#:** | **DOB:** Month/Day/Year | **AGE:**

TELEPHONE#: | **Emergency Contact Name:** | **Emergency Contact Ph#:**

I hereby voluntarily request and authorize The University of Tampa Counseling Services to release/receive from

_____

(Name/Title) (Agency Address) (Phone #)

written or verbal psychiatric/psychological information from my health records as outlined in Florida Statutes 90.242 and 490.32

Specific type of information to be disclosed:

- ❑ Assessment/evaluation/progress notes and treatment recommendation
- ❑ Release of full psychiatric records to the designated medical/psychiatric professional
- ❑ Diagnosis and/or medications
- ❑ Appointments attended/treatment dates

Purpose of Disclosure: _____

I understand that this information is protected under Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Further, I understand that I may revoke this consent at any time with written notice to the counselor/practitioner. This authorization is in effect until graduation.

By signing below, I acknowledge that I have read and understand this authorization.

Signature of Patient or Guardian | **Relation to Patient** | **Date:** Month/Day/Year

Signature of HealthCare Provider | **Printed Name/Title of Health Care Provider** | **Date:** Month/Day/Year

Signature of Witness | **Printed Name of Witness** | **Date:** Month/Day/Year

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