MSU Texas
Counseling Center
AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Client Name: _____ M# _____ DOB: _____

I Hereby Authorize:
Entity: Midwestern State University Counseling Center
Address: 3410 Taft Blvd.
City: Wichita Falls State: TX Zip: 76308
Contact Person: _____ Phone #: 940-397-4618

☐ **To Release to:** **and/or** ☐ **To Obtain From:**

Entity: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Phone #: _____

Information Pertaining to: (check all that apply)

☐ Academic
☐ Career
☐ Client ID (Phone, Address)
☐ Personal Counseling
☐ Progress Notes
☐ Psychological Evaluation
☐ Disability
☐ Verbal Exchange

☐ Other: _____

Note: The above information may include drug and alcohol/mental health/communicable disease information, including HIV test results or AIDS related information.

This release is for the following reason(s) (be specific): _____
_____

The authorizing person through written notice may revoke this authorization at any time. If not earlier revoked, this consent shall expire on:
_____ or Not to exceed One (1) year from date of client signature.
Date or Event

Form must be completed before signing

_____
Client Signature/ Date
Legal Representative of Client

_____
Counselor

_____
Witness Date

This consent is hereby revoked at my request:

_____
Client Signature/ Date
Legal Representative of Client

_____
Counselor Date

_____
Witness Date