LAWRENCE UNIVERSITY

I, _____, (student name) DOB: _____ (enter date of birth)

authorize Lawrence University Counseling Services: TO DISCLOSE TO TO OBTAIN FROM

(Name of Person and/or Organization) (Address/City/State/Zip)

THE FOLLOWING INFORMATION (check all that apply)

Mental Health Records	Initial Evaluation	Confirmation Letter to Referral Source
Medical Records	Progress Notes	Psychological/Psychiatrist Evaluation
Discharge Summary	Academic Records	Other (Please specifiy):

VIA: Verbal Written Fax Email

FOR THE PURPOSE OF:

Facilitating family/significant other involvement	Facilitating referral
Establishing diagnosis and treatment plan	Coordination of treatment
Facilitate academic and/or administrative decisions	Other (Please specify):

I understand that my records are protected under Federal and State confidentiality laws and regulations and may not 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 for the extent

Witness:_____ **Date:**

Please send records to: Lawrence University Counseling Services, SPC 3, 711 E. Boldt Way, Appleton WI 54911 // 920-832-6574 (phone) 920-832-7488 (fax)