CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Edgewood College Health Center
1000 Edgewood College Drive
Madison, WI 53711-1997

Individual who is subject of record:

Name:			Edgewood ID #:		
Address:					
City:		State:		Zip:	
Phone:					

Name and address of agency, organization, or individual being authorized to receive information:

Name:					
Organization:					
Address:					
City:		State:		Zip:	
Phone:		Fax:			

Information May Be Released by:

Organization: **Edgewood College Health Center**

Address: **1000 Edgewood College Drive**

City, State, Zip: **Madison, WI, 53711**

Phone: **608-663-8334** Fax: **608-663-3394**

Type of Information Requested:

☐ Recent psychiatric/psychological assessment information
☐ Level of current psychological functioning
☐ Summary of treatment
☐ Treatment recommendations
☐ Medical Records
☐ Other information:_____

By signing below, I hereby authorize disclosure of written and verbal information to the person(s) as specified above. Authorization expires ___ month(s) from the date of signature. I have the right to revoke this permission with a 24 hour notice.

_____
Printed Name

_____ _____
Signature Date