

Interagency Release of Information

TO: _____ RE: _____
(Agency to release information) (Client's name)

(Agency's address) (SS# or DOB) _____

(Client's address) _____

I, _____, authorize release of the following specific information:

information regarding attendance, results of evaluation, diagnosis (to include substance abuse or dependence, and mental health), recommendations for treatment and other follow-up, financial or billing information, and any other pertinent information including disruptive behavior during program or evaluation.

TO: Adrian College Student Affairs
Located at: 110 S Madison St, Adrian, MI 49221-2575
Phone/fax: 517.264.3142/517.264-3331
Specifically Agents: Janna D'Amico, Associate Dean for Student Life at Adrian College and Monique Savage, Director of Counseling at Adrian College for the specific purpose of:

facilitating continuity of care and the verification of program completion/non-completion.

This release will be valid only until _____ (date, up to a year hence) or until its purpose has been met, whichever comes first. I understand that only the requested information will be made available, and it will be used only for the purpose stated and will be treated confidentially.

This consent is subject to revocation at any time except to the extent that action authorized by it has already been taken.

_____ (Date Signed) _____ (Client's Signature)

or

_____ Parent's, Legal Guardian's Signature

Note: Persons or agencies receiving information released by this form may not further release it without the informed written consent of the client.

_____ Date Signed _____ (Associate Dean for Student Affairs or other Adrian College Authorized Signature)