AUTHORIZATION TO RELEASE INFORMATION

Duquesne University Counseling and Wellbeing Center
636 Fisher Hall
Pittsburgh, PA 15282
Tel: (412) 396-6204
Fax: (412) 396-4194

Client Name: _____ **Date of Birth:** _____

AGENCY OR PERSON REQUESTING INFORMATION:

☐ Duquesne University Counseling and Wellbeing Center
636 Fisher Hall
Pittsburgh, PA 15282-0203
Attn: _____

☐ Other: _____
_____
_____
Attn: _____

AGENCY RELEASING INFORMATION:

☐ Duquesne University Counseling and Wellbeing Center
636 Fisher Hall
Pittsburgh, PA 15282-0203

☐ Other: _____
_____
_____

INFORMATION NEEDED:

The individual named above has requested services from our agency and we need the following information:

☐ Counseling/Therapy Records, Intake Evaluations and Social History Data

☐ Psychiatric Evaluation Results

☐ Residential/Inpatient Records

☐ Results of Medical Treatment or Medical Records/Lab Reports

☐ Alcohol/Drug Treatment Records

☐ Psychological Testing Reports

☐ Consultation between Agencies listed above regarding: _____
_____

☐ Other: _____

AUTHORIZATION:

I authorize the agency or persons listed above to disclose the specified information. I understand the purpose for releasing this information. I may revoke this consent at any time and, in any event, this consent expires automatically in 360days. I understand that I have a right to receive a copy of this authorization if I so request.

_____ _____ _____
Staff Signature Client Signature Date