SUNY POLYTECHNIC INSTITUTE

Wellness Center: Counseling Services
Campus Center, Suite 217
100 Seymour Road
Utica, NY 13502

Phone: 315-792-7172 Fax: 315-792-7371

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Counseling Services at the Wellness Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____ Phone No.:_____
(Print full name)

Address: _____
(Street Address) (City) (State) (Zip)

Authorize **SUNY Poly Counseling Services to:**

Release information to: ◯ Obtain **information from:** _____

◯ Exchange **information with:** _____

Following information pertaining to myself:

- ☐ treatment summary
- ☐ psychological test results
- ☐ psychiatric evaluation/medication history
- ☐ other(specify):_____
- ☐ history/intake
- ☐ attendance at sessions
- ☐ compliance with services

for the purpose of:

- ☐ fulfilling Judicial Sanction requirements
- ☐ evaluation/assessment and/or coordinating treatment efforts
- ☐ other (specify):_____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or when I am no longer receiving services, whichever occurs first. I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Signature of Student (Date) Date of Birth

_____
Signature of Witness (Date)