

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:	
Phone:		Zip:	

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

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

Information May Be Released to:

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
- Summary of treatment
- Medical Records
- Level of current psychological functioning
- Treatment recommendations
- 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.

Signature

Date