Authorization to Exchange Confidential Information Between
the Counseling Center and the Student Health Center

I, ________________________________, authorize the clinical staff of the Counseling
(Patient/Client’s Name-Printed)
Center and medical providers at the Student Health Center to exchange with each other all
information, written and oral, that may be related to my mental, emotional, and physical care so
that I may obtain psychological, psychiatric, or medical treatment. I understand that no such
exchange or disclosure of my records can be made without my written consent, unless otherwise
provided by law. This exchange of information may occur by telephone, face-to-face
conversation, electronic record, fax, or campus mail. I understand that I may cancel this
authorization at any time, except to the extent that information has already been exchanged. This
authorization expires six months from the date signed below.

_________________________________________   _______________________
Patient/Client’s Signature                     Date

_________________________________________
ID Number

Fax to the Center (704) 687-6343 or the Student Health Center (704) 687-3211.