HEALTH & COUNSELING SERVICES
COUNSELING CLINIC
EASTERN ILLINOIS UNIVERSITY™

Authorization to Release and Exchange Information/Referral Information

At the EIU Counseling Clinic, we support student well-being through coordinated care with relevant campus and community providers. With your consent, we may exchange limited, relevant information to support your emotional, academic, and personal success. This form authorizes the disclosure and/or exchange of confidential information between the EIU Counseling Clinic and the selected parties. Only information necessary to support your care will be shared. You have the right to inspect, revoke, or limit this authorization at any time in writing.

Student Name: _____ Date of Birth: _____ E Number: _____

I authorize the EIU Counseling Clinic to:

☐ Release information to ☐ Obtain information from ☐ Exchange (release and obtain) information with

Concerning my care from (date or range): _____

Recipient(s): ***(Check all that apply)***

EIU Offices / Departments

☐ EIU/ Sarah Bush Medical Clinic
☐ Dean of Students Office
☐ Accessibility and Accommodations
☐ Career Services
☐ Academic Support Center
☐ TRIO
☐ Health Education Resource Center
☐ Office of Belonging and Engagement
☐ Housing
☐ Title IX Director/Investigator
☐ EIU Advisor: _____
☐ EIU Professor: _____
☐ Other EIU Department: _____

Community Providers / Other

☐ LifeLinks Community Mental Health
☐ Sarah Bush Lincoln Health
☐ Prevail
☐ HOPE of East Central Illinois
☐KC Counseling
☐ Parent/friend/roommate: _____
☐ Other (name/organization): _____

Information to be Disclosed/Exchanged: ***(Check all that apply)***

☐Attendance and participation
☐ Treatment goals and progress
☐ Risk or safety concerns
☐ Referral information
☐ Progress notes from my record
☐ Assessments/Intakes from my record
☐ Treatment Summary
☐ Recommendations relevant to my care at EIU
☐ Other (specify): _____

Purpose of Disclosure: ***(Check all that apply)***

☐Continuity of care
☐Referral/care coordination
☐Support / advocacy
☐Other (specify):_____

Preferred Method(s) of Communication:

☐ Verbal (phone or in-person) ☐ Written (fax, email, or mail) ☐ Both

Signatures on back page

I understand that:

- I can inspect or request a copy of the information exchanged.
- I understand that this authorization allows the Counseling Clinic and the departments I have selected to collaborate in providing my care
- In the case of verbal communication, I may request a summary of what was discussed.
- I may revoke this authorization at any time by submitting written notice to the EIU Counseling Clinic.
- Revocation does not apply to any information already released under this authorization.
- This consent will expire one year from the date signed OR on this date: _____

Signatures

Student Signature: _____ **Date:** _____
(Required for clients age 12 and older)

Witness/Counselor Signature: _____ **Date:** _____

Notice to Receiving Agency/Person
Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information without the client's written consent.