

**UNIVERSITY OF ARKANSAS  
COUNSELING AND PSYCHOLOGICAL  
SERVICES**

**525 North Garland Avenue  
1 University of Arkansas  
Fayetteville, Arkansas 72701-1201  
(479) 575-5276**

CAPS Use Only
Copy given to client?
<input type="checkbox"/> Yes
<input type="checkbox"/> No

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I,			
	Name	Student ID#	Date of Birth
	Address		Telephone Number
authorize	Counseling and Psychological Services, 525 N. Garland Ave., U of A, Fayetteville, AR 72701		
to release the following information from my records:			
Summary of Contacts and Treatment including Diagnosis and Medication			
to			
for the purpose of			

The information incorporated in this release has been explained to me.

I understand the following: (a) the exact nature of the information to be released; (b) to whom the information is being released; (c) why the information is being requested and how it will be used; (d) that the receiving party will be instructed not to release the information to other individuals or agencies; and (e) that I am responsible for any repercussions which might occur due to my release of or failure to release the information specified above. I also understand that I may revoke this authorization at any future point in time by filling out the section at the bottom of this page. However, I understand that once the requested information is released, CAPS has no further control or responsibility as to the use or re-release of the released information. This authorization will expire one year from date unless revoked prior to that time.

(Signature of Client)	(Date)	(Signature of Witness)	(Date)

**STATE OF ARKANSAS  
COUNTY WASHINGTON**

Subscribed and sworn to before me a Notary Public on this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

**-SEAL-**

\_\_\_\_\_  
Signature of Notary Public or other authorized official

I revoke the above permission on this Day: \_\_\_\_\_ am/pm  
Date Time

\_\_\_\_\_  
Client Name (Please print)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Witness Signature

**Please Note:** This form must be signed and dated by the client and a witness (who verifies the client's informed consent) before the request for release of confidential information can be processed.