

Information S	Sent
Date	
Staff	

## CONSENT TO RELEASE INFORMATION

Specific information to be released/disclosed by M  ACT assessment Testing report Counseling of the about Treatment progress  I understand this information can be used for:	
Specific information to be released/disclosed by M  ACT assessment	to release/exchange informat
Specific information to be released/disclosed by Maction     ACT assessment	
□ ACT assessment □ Testing report Counseling of Drug and Alcohol issues □ All of the abs □ Treatment progress □ Other □ I understand this information can be used for:  □ Academic Considerations □ Contact with □ Professional aftercare planning □ Family invol □ Continuation of treatment □ All of the absence of confidential records. I also understand that I am giving my perfection is not effective until delivered in writing to the Counservices office. A copy of this consent and a notation concerning the perse is closure was made shall be included with my original records in the Councervices office. The person who receives the records to whimay not disclose them to anyone else without my separate written consent provider who makes a disclosure permitted by law.  his release expires in 12 months unless another date is specified here: □ Name (Print): □ Institute of the provider who makes a disclosure permitted by law.	(Fax Number)
□ Treatment summary □ Counseling □ Drug and Alcohol issues □ All of the ab □ Treatment progress □ Other □ I understand this information can be used for:  □ Academic Considerations □ Contact with □ Professional aftercare planning □ Family invol □ Continuation of treatment □ All of the ab □ All of the	IGA:
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□ Academic Considerations □ Contact with □ Professional aftercare planning □ Family invol □ Continuation of treatment □ All of the abuse the person signing this consent, I understand that I am giving my personal person	
as the person signing this consent, I understand that I am giving my permissclosure of confidential records. I also understand that I have the right to that my revocation is not effective until delivered in writing to the Counservices office. A copy of this consent and a notation concerning the persisclosure was made shall be included with my original records in the Councessibility Services office. The person who receives the records to whimay not disclose them to anyone else without my separate written consent provider who makes a disclosure permitted by law.  This release expires in 12 months unless another date is specified here:  Jame (Print):	vement
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Jame (Print):	revoke this consent, but seling & Accessibility ons or agencies to which bunseling Center or ch this consent pertains
ignature:	
hate: Address:	
rucrudicss	
taff Witness:	
ermission to transmit documentation by fax (check one): Yes	NoClient Init

Middle Georgia State University Counseling & Accessibility Services

- 1100 Second Street SE Cochran, GA 31014 Phone: (478) 934-3023 Fax: (478) 934-3342
- 100 University Pkwy Macon, GA 31206 Phone: (478) 471-2985 Fax: (478) 471-5730