KENNESAW STATE UNIVERSITY

Counseling & Psychological Services (CPS)

Kennesaw Campus
585 Cobb Ave, NW
MD 0117, KH2401
Kennesaw, GA 30144
P: 470-578-6600
F: 470-578-9102

Marietta Campus
860 Rossbacher Way
MD 9004, A170
Marietta, GA 30060
P: 470-578-7391
F: 470-578-9236

Center for Young Adult Addiction and Recovery

Kennesaw Campus
430 Bartow Ave
MD 2403, UC222
Kennesaw, GA 30144
P: 470-578-2538
F: 470-578-9203

AUTHORIZATION TO RELEASE INFORMATION – (MUST BE COMPLETED IN FULL)

I, _____
Please Print Legal Name

Birth Date: _____ KSU ID# _____

hereby request and authorize Kennesaw State University's Counseling & Psychological Services (CPS) and/or the Center for Young Adult Addiction and Recovery (CYAAR) to

Check all that apply: ☐ **Release To** ☐ **Request From**

The following person(s) or organization or department listed below:

_____
(Name/Agency – please provide complete information)

_____
(Address)

_____
(Phone, Fax)

(Check all that apply, under other, please be specific)

☐ Consultations	☐ Psychosocial History	☐ Telephone Calls/Verbal Communication
☐ Treatment/Continuing Care Plan	☐ Psychological Evaluation	
☐ Treatment Attendance	☐ Initial Clinical Assessment	☐ Email
☐ Discharge Paperwork	☐ ADHD diagnosis, medication log	☐ Laboratory/Radiology Reports

Other: _____

I understand: That this information is to assist the above-named agency or person(s) in my treatment or in service on my behalf. Further, that this authorization statement may be revoked by me at any time in writing except to the extent that actions have already been taken in reliance on this authorization statement.

Further, this authorization statement will automatically expire one year from the date of signature, or at such time as I complete or terminate the services provided to me, or unless I specify an earlier date or event here: _____.

Further, no information received through this authorization statement will be released to any other person or agency without my specific written consent to do so.

I am willing that a reproduction of this authorization statement be accepted with the same authority as the original.

Student Signature: _____ Date: _____

USE SPACE ONLY IF CLIENT WITHDRAWS CONSENT

_____ _____
(Date this authorization is revoked) (Student signature)