Lander University Counseling and Disability Services
Professional Disclosure Information and Consent Form
(864-388-8288 or 864-388-8885)

Name _____L# _____ Date of Birth _____

Phone# (primary) _____ (other) _____ Email _____

Permanent Address _____

Student Address_____

Emergency Contact Information: By signing below, I give the counselor permission to let this contact know I am in services.

Name _____Relationship _____Phone# _____

Current Medications (What are they prescribed for?)

I hereby authorize Lander University Counseling and Disability Services to release and/or receive the information and records specified below:

Release To/From: Lander University Personnel

Information to Be Released or Requested:

Form Information Can Be Released In: XX verbal XX written XX electronic __ other

Purpose of this release is to help the student be successful and to case manage the student's mental health status while at Lander University and/or any information needed to establish a disability case or accommodations .

Expiration Date of Release: Four years from date on this release.

I understand that all information shared during the course of counseling is protected and kept confidential except under the following circumstances: *a written consent is signed allowing disclosure; suicidal intentions and/or actions; homicidal intentions and/or actions; committing child abuse; or committing elder abuse. I also understand that I can revoke this release at any time by signing on the revocation line.*

I understand that I may not be allowed to return to counseling if I have not followed up with or kept referral appointments. I also understand that if I am referred to any other health care provider, I will be responsible for fees accrued as a result of this referral.

I understand that my family or legal guardian may be contacted if the counselor deems it necessary for my care and safety.

_____ _____
Student Signature **Date**

_____ _____
Witness Signature **Date**

_____ _____
Signature of Revocation **Date**