



founded in 1872

LANDER UNIVERSITY

*Student Wellness Center*

Lander University

Student Wellness Center

### Authorization to Release/Exchange Confidential Information

L# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

I \_\_\_\_\_ authorize the Student Wellness Center of Lander University to:

\_\_\_\_\_ release to:

\_\_\_\_\_ obtain from:

\_\_\_\_\_ exchange with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is for the purpose of evaluation/assessment and/or coordinating treatment efforts. I understand that I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that the information has already been released).

\_\_\_\_\_  
Student signature