GRACE COLLEGE
Student Authorization for Release of Information

Student Name:	**Date of Birth:**
Alternate Name:	**Student ID#:**

You are welcome to complete and submit multiple forms, limiting the information made available to different individuals. If the information to be released is the same, feel free to include multiple individuals on one form. Note that a printing fee, not to exceed $1 per page, will be charged by Grace for furnishing copies of the requested client records; and we do our best to mail or fax records within 14-21 days of the request.

HEALTH INFORMATION TO RELEASE (please mark all that apply):
☐ All health/medical information
☐ Any pertinent health/medical information
☐ Any pertinent health/medical information for the following incident:

_____

COUNSELING INFORMATION TO RELEASE (please mark all that apply):
☐ Session Participation Only ☐ Intake Assessment ☐ Termination Summary
☐ All Records ☐ Safety Plan ☐ Attendance Records
☐ Progress Notes ☐ Required Education & Recommendations
☐ Other:

COUNSELING INFORMATION PURPOSE OF RELEASE - Disclosure of the designated mental health records are for the following purpose:
☐ Session Participation Only ☐ Academic Accommodations ☐ Progress Reporting
☐ Litigation/Criminal Proceedings ☐ Medical Withdrawal ☐ Family or Friends
☐ Permission to return to work/school ☐ Coordination with/Other:

_____

RELEASE TO WHOM – The selected information may be released to all of the following people and/or offices:
☐ Self
☐ Disability Services Coordinator
☐ Global Studies
☐ Grace Student Affairs (specify):
☐ Athletic Department (specify):
☐ Family member/guardian/spouse (specify):
☐ Medical or Mental Health Provider (specify):
☐ Other (name & relationship):

HOW TO RELEASE – Mark the desired means of release and if applicable include the fax number or address. Although you may email a scan or picture of this authorization form, we cannot release the records by email.
☐ Verbal ☐ Pick up at Health Services
☐ Participate in counseling session(s) ☐ Pick up at Counseling Services
☐ Mail records to: ☐ Fax records to:
☐ Letter addressing disclosed information ☐ Safety/Emergency Plan Internal Document

Expiration of Authorization:
☐ One year from signature (maximum):
☐ Other date:
Except to the extent that action already has been taken, at any time this consent may be revoked by you in writing.

Student Signature: _____ Date: _____
Witness Signature: _____ Date: _____

Grace College, 1 Lancer Way, Winona Lake, IN 46590 P.574.372.5100, ext. 6472 F.574.372.5295 Email: healthservices@grace.edu