Consent for Release of Information

Lawrence Technological University
University Counseling Services

Client Name:			
Date of Birth:		SSN	

I hereby authorize:

Lawrence Technological University **University Counseling Services** **Division of Student Affairs** **21000 West Ten Mile Road** **Southfield, MI 48075**	_____	To Release
	_____	To Get Information From

____

Name of individual or institution

City		State		Zip	

The following information is to be released (list specific types of information):

For the visits covering the dates from		to	

For the specific purpose of:	

I release the above cited individuals or facilities of any legal liability that may arise from the release of the information requested. I understand that this authorization for release of information will automatically expire 6 months from the date of this release or on

Date	

____

Signature		Date	

I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by me. I hereby revoke my consent for the release of the above information.

____

Signature		Date	

____

Witness		Position		Date	

Information sent date and signature of sender: ______________________________