

## CONSENT FOR RELEASE OF INFORMATION

California State University, Fresno  
Student Health and Counseling Center  
5044 N. Barton Avenue MS/HC81  
Fresno, Ca 93740-8012  
Phone: 559.278.2734 • Fax: 559.278.7602

Permission is hereby given to: \_\_\_\_\_ / Counseling and Psychological Services to:

\_\_\_\_\_ Obtain Information from:  
Student's Initials

\_\_\_\_\_ Provide Information to:  
Student's Initials

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### Regarding:

Place student identification here:

### Specific information to be obtained or released:

Written/verbal communication to facilitate treatment, to coordinate services, or in the event of a crisis or emergency; also to leave messages for client when client cannot be reached at usual phone number.

*I hereby authorize the persons or agencies named above to release the information described above. I also understand that I have the right to cancel my permission to release information at any time before it is released and that this signed consent will expire on the date given below.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Parent, if Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Expiration Date