ANTIOCH COLLEGE COUNSELING SERVICES

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

I hereby authorize Person/Entity Name __Nzingha Dalila, EdD, LPCC-S, LCDC-III_____

Antioch College Counseling Center

One Morgan Place, Pennell House

Yellow Springs, OH 45387

To release counseling information and/or records for:

Student Name: _____

Date of birth: _____

The information is to be used or disclosed to the following person(s) or organizations:

Person/Entity Name: _____

Phone/Email: _____

The purpose of the use or disclosure is: { } at the request of the student { } continuity of care

I understand that this authorization extends to all or any part of the records/information designated below which may include treatment for behavioral health and/or alcohol/drug abuse. The information to be used or released includes:

{ } intake information { } progress notes { } treatment plans { } psychological testing

{ } collateral communication { } other _____

This authorization is limited to only that information that I have requested above to be used or disclosed to the person(s)/facilities named herein. I hereby release Antioch College Counseling Center and its' staff for all legal responsibilities or liability that may arise from the use or disclosure of records and other information in reliance on this authorization.

I understand that I have the right to revoke this authorization at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization. This authorization will expire after one year post signing.

_____ (Date) (Student Signature)

____ (Date) (Witness)