**Practicum Laboratory**

**Authorization for Release of Information Form**

(This form can only be mailed or hand-delivered – and not faxed.)

I hereby authorize the exchange of (psychological, educational, health, rehabilitation, etc.) information concerning:

Client’s Name:

Date of Birth: NAU ID / Driver’s Lic.:

Between the following agencies and/or persons:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor-in-training at N.A.U. Practicum Laboratory / Supervisor at N.A.U. Practicum Laboratory

AND

Name of Person/Agency:

Address:

Of particular interest is the following information:

**It is recognized that this is confidential information and that it will not be released to other individuals. This release is good for six months from the date signed and may be revoked at any time at the written request of the client.**

Counselor-in-training’s Signature Date

Client’s Signature Date

Supervisor’s Signature Date