

**UNIVERSITY COUNSELING SERVICES  
TRUMAN STATE UNIVERSITY  
100 E. Normal St.  
Kirksville, MO 63501**

**660-785-4014  
FAX: 660-785-7444  
ucs@truman.edu  
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**CONSENT AND AUTHORIZATION TO EXCHANGE INFORMATION**

Pursuant to federal guidelines concerning my right to confidentiality, and state law concerning privileged

communication, I, \_\_\_\_\_ on \_\_\_\_\_  
(name) (today's date)

authorize University Counseling Services at Truman State University to exchange information with

\_\_\_\_\_  
(name of specific person or organization)

at \_\_\_\_\_  
(address/telephone number, etc.)

Purpose of disclosure and/or any limitations:

\_\_\_\_\_  
(specific nature; what kind and extent of information to be exchanged)

This authorization is valid for 12 months from the above listed date.

I understand that I may revoke this consent to exchange information at any time prior to the stated expiration. I also understand that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

I have discussed with the client the rationale of the need, the potential concerns, and the limitations that exist with this release of information. I have also verified the identity of the person signing this form.

\_\_\_\_\_  
UCS Staff Signature

\_\_\_\_\_  
Date

