UNIVERSITY COUNSELING SERVICES
TRUMAN STATE UNIVERSITY
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Kirksville, MO 63501

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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, _____ Date of Birth _____
(name) (mm/dd/yyyy)

on _____ authorize University Counseling Services at Truman State University
(today's date)

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