PERMISSION FOR VERIFICATION / RELEASE OF INFORMATION

I grant permission for _____
Name of Provider / Department

to discuss my visit(s) / attendance on _____ at:
Date(s)

☐ Counseling and Psych Services (CAPS) ☐ General Medicine
☐ Nutrition ☐ Oasis Center ☐ Pharmacy ☐ Physical Therapy
☐ Sports Medicine ☐ Urgent Care ☐ Women's Health Clinic
☐ Dean of Students ☐ UA Department/Organization _____
☐ Other: _____

With: _____
Name of Person to be Consulted *Telephone Number*

My provider has discussed the purpose of this telephone consult with me and I give my permission for my information to be released:

(please initial inside circle)

◯ without any exception
◯ with the following exceptions _____

_____

_____ _____
Signature *Date*

_____ _____
Printed Name *Student I.D. Number*

_____ _____
Witness *Date*

F-GENADM 3/2014