



Moore Moore Student Health Center
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CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

Pursuant to Federal Guidelines concerning my right to confidentiality, I

Name of Client

authorize Person(s) and/or Agency

to release my records or information concerning my records to:

Name of Specific Person or Organization

concerning treatment during the period:

Dates of Treatment/Specify Dates for A&D Treatment

I specifically consent only to the release of information or records (including A&D treatment information as applicable) pertaining to:

Specific Nature, Reason for, and Extent of Information To Be Released

I understand that I may revoke this consent to release information at any time. However, I also understand that any release made prior to my revocation and which was made in reliance upon the authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such times, this authorization to release information shall expire:

Event or Date - 1 Year Maximum

At that time no express revocation shall be needed to terminate my consent.

Client Signature Date

Witness Signature Date

Parent or Guardian Date
(if patient is under 18)