Print Form

MADISON AREA | TECHNICAL COLLEGE

Counseling Services

Authorization for Release of Information & Records

I authorize and request _____ of Madison College Counseling Services to: ☐ Release to ☐ Obtain from

Individual _____ Phone Number _____

Agency _____ Fax Number _____

Address _____ Email _____

City _____ State _____ Zip Code _____ Relationship to Client _____

The following information from the record of:

Client Name _____ Social Security# _____

Phone Number _____ or Date of Birth _____

Pertaining to:

- ☐ Academic Performance
- ☐ Alcohol or Other Drug Abuse
- ☐ Psychological Evaluations
- ☐ Career/Vocational Counseling
- ☐ Psychiatric Evaluations
- ☐ Other
- ☐ Personal Counseling
- ☐ Educational Records

_____

This information will be used for:

_____

This authorization is in effect from _____ until _____ unless revoked in writing by me.

_____ _____

Client Signature Date

_____ _____

Staff Witness Signature Date

Madison College 1701 Wright St, Madison, WI 53704 - (608) 246-6076 - Fax (608) 243-4274 - counselingservices@madisoncollege.edu