IDAHO STATE UNIVERSITY COUNSELING AND TESTING SERVICE

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Client Name: _____ Date of Birth: _____ Bengal ID:_____

Authorization is hereby granted to ISU Counseling & Testing Service staff to exchange relevant clinical information with:

☐ **ISU Health Center**
990 Cesar Chavez Ave, Stop 8311, Pocatello, ID 83209
Phone: 208-282-2330, Fax: 208-282-4036

☐ **ISU Student Affairs**
PSUB, Rm 204, Stop 8123, Pocatello, ID 83209
Phone: 208-282-2794

☐ **ISU Disability Services**
Rendezvous, Rm125, Stop 8121, Pocatello, ID 83209
Phone: 208-282-3599, Fax: 208-282-4617

☐ **ISU International Programs Office**
Museum Bldg, Rm 426, Stop 8038, Pocatello, ID 83209
Phone: 208-282-4320, Fax: 208-282-2924

☐ **ISU Housing Office**
745 S. 5th Ave, Pocatello, ID 83201
Phone: 208-282-2120, Fax: 208-282-3786

☐ **ISU Psychology Clinic**
525 Garrison Hall, Stop 8021, Pocatello, ID 83209
Phone: 208-282-2329, Fax: 208-282-5411

☐ **Pocatello Counseling Clinic**
725 Garrison Hall, Stop 8120, Pocatello, ID 83209
Phone: 208-240-1609, Fax: 208-282-2583

☐ **ISU Center for New Directions**
364 Christensen Bldg, Stop 8380, Pocatello, ID 83209
Phone: 208-282-2454, Fax: 208-282-5160

☐ **ISU Financial Aid**
Museum Bldg, Rm 337, Stop 8077, Pocatello, ID 83209
Phone: 208-282-2756, Fax: 208-282-4755

☐ **ISU Medical Withdrawal Committee**
921 S. 8th Ave, Stop 8311, Pocatello, ID 83209
Phone: 208-282-2330, Fax: 208-282-4036

Other Person/Organization: _____

Address: _____ Phone: _____ Fax: _____

ISU Counseling and Testing Service
May release the following:

_____Treatment Summary
_____Dates of Service
_____Other (Specify) _____

ISU Counseling and Testing Service
May obtain the following:

_____Medical Diagnosis and Treatment Information
_____Discharge Summary
_____Treatment Summary
_____Psychiatric/Psychological Evaluations
_____Substance Abuse Treatment Summary
_____Other (Specify) _____

For the following purpose: (Check all that apply)

☐ Permission to discuss care ☐ Medical Consultation ☐ Documentation of Services ☐ Letter/Form
☐ Other: _____

This authorization will expire on: _____ If no date, the authorization will expire 1 year from date of signature.

I understand that I may revoke this consent at any time, that my revocation must be submitted in writing to Counseling and Testing Service, and that the revocation shall be effective except for information already released under this authorization.

To the receiving party of this information: This information has been disclosed to you for the *sole purpose stated in this consent and should not be released to any third party*. Any other use of this information without the expressed written consent of the client is prohibited. These records may be protected by Federal Regulation (42 CFR part 2).

Client Signature: _____ Date: _____

Idaho State University

Counseling and Testing Service
921 S. 8th Avenue, Stop 8027
Graveley Hall South, Rm 351
Pocatello ID 83209
PH: 208-282-2130
FAX: 208-282-4279

Counseling, Testing and Career Services
1784 Science Center Drive, Stop 8150
Bennion Student Union, Rm 223
Idaho Falls, ID 83402
PH: 208-282-7750
FAX: 208-282-7755

Counseling and Testing Service
1311 East Central Drive
Second Floor, Rm 841C
Meridian, ID 83642
PH: 208-373-1723
FAX: 208-373-1826