

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give permission for _____
of the Longwood University Counseling And Psychological Services staff to exchange
information from the Fall Spring Summer semester of _____ with
(Year)

(Name) (Phone)

(Address)

Information being released (*please be as specific as possible*):

For the purpose of:

I understand this to be professional and confidential information and that it may be
communicated in written and/or oral form.

(Signature)

(Name--Please Print)

(Longwood ID#)

(Local Address)

(Phone Number)

(Date)