Carson-Newman University
Counseling Services
Consent to Disclosure/Obtain Information

I, ___________________________ (date of birth _______________), voluntarily consent to the disclosure by Counseling Services or Counseling Services to obtain information, and its individual counselors, of any and all matters related to me arising out of Counseling, Administrators and/or faculty of the University who I agree have a legitimate educational interest in the information.

_______ A health care provider for the purpose of informing the provider, so that the provider may better assist me.

_______ A person I wish to receive/obtain this information for the following purpose:

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Student _________________________________ Witness________________________

Today's Date ____________________________

Dates/Length Consent is Valid ___________________________

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Withdrawal of Consent:_________________________________ Date: ____________

Updated Aug 2015