



**AUTHORIZATION FOR RELEASE OF INFORMATION
For Counseling & Psychological Services and SHARE
University Health Services**

McCosh Health Center, Princeton, NJ 08544
Counseling Psychological Services - Ph. 609-258-3285, Fax 609-258-7636
Sexual Harassment/Assault Advising, Resources & Education – Ph 609-258-3310

STATUS – please check one

____ PU Undergraduate Class ____
____ PU Grad Student- Last Year Attended ____
____ Dependent
____ Faculty/Staff

I understand that the University will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this revocation.

Client Name _____ Date of Birth _____ Email _____ Ph _____

I hereby revoke my authorization to release my records from _____ to _____.

Effective Date _____

Signature of Client or Legal Representative _____

Date _____

Printed Name of Client or Legal Representative _____

Relationship to Client _____

Witness _____

Date _____