CONSENT TO RELEASE INFORMATION

Office of Disability Services
3 College Drive
Brunswick, GA 31520
912.279.5806

NAME: ____ **CCGA ID:** ___________________________________

I, the undersigned, hereby authorize:__________________________________ to release/exchange information concerning the above-named person to:

Jennifer Zak, M.S., LPC, Director of Counseling and Disability Services
(Name of Person or Institution)

3 College Drive Brunswick, Georgia 31520
(Address)

Specific type of information to be disclosed/exchanged:

❑ Assessment	❑ Testing Reports
❑ Attendance	❑ Recommendations
❑ Treatment Progress	❑ Counseling Records
❑ Drug/Alcohol Issues	❑ All of the Above
❑ Treatment Summary	❑ Other____________________

I understand that the information is to be used for:

❑ Academic Considerations	❑ Family Involvement
❑ Contact with Referral Source	❑ Continuity of Treatment
❑ Professional Aftercare Planning	❑ Other ____________________

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential records. I understand that this release shall be valid throughout my enrollment at College of Coastal Georgia. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records in the Office of Disability Services. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

Name (Print):____

Name (Signature):____

Date:____

Witness:____

Revised 09/2011