**Lane Community College**
**Counseling Department**

Confidential Record

## CONSENT TO RELEASE

### Confidential Information

I, hereby authorize _____ to exchange information about:
LCC Counselor

_____ with: _____
Student Name & Date of Birth  Agency and/or Individual

Extent of information to be disclosed: _____

_____

Purpose for this disclosure of information:
- ☐ A. Use of medication
- ☐ B. Develop treatment plan
- ☐ C. Continuity of care
- ☐ D. Other _____

_____

_____

I may revoke this release, in writing, at any time, except to the extent of action that has already been taken.

Date, event, or condition upon which it expires: _____

_____

It is understood that the information specified above will not be released to any third party agency or individual without my knowledge and consent. The confidentiality of this information is protected by state laws (ORS 192.500, ORS 179.505) and federal law (PL93-380, the Family Education Rights and Privacy Act of 1974).

_____ _____
Signature of Student or guardian  Date

_____ _____
Witness  Date

Rev. 8/31/11