West Virginia University
Office of Student Conduct

Authorization to Obtain Information

_____ ____ / ____/ ____
Name Date

_____ ____ / ____/ ____
Student ID# Date of Birth

I authorize the West Virginia University Office of Student Conduct **TO OBTAIN INFORMATION** from *WELL WVU Carruth Center for Psychological and Psychiatric Services.*

I understand that this information may include information related to my diagnosis, prognosis, and/or treatment. I voluntarily consent to the release of this information. I certify that I understand the preceding statements.

Purpose for obtaining information _____

_____

INFORMATION TO BE OBTAINED: (check all that apply)

___ No Limitation

___ Assessment/Evaluation

___ Summary of Treatment

___ Verbal & written communication concerning progress of care, aftercare, & recommendations

___ Other _____

This authorization is valid through ____ / ____/ ____ unless revoked by my written or verbal instruction.

_____ ____ / ____/ ____
Signature Date

Please hand deliver or mail to:
660 N High St.
WVU Morgan House
PO Box 6430
Morgantown, WV 26506