COLUMBIA HEALTH
Sexual Violence Response

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AUTHORIZATION FOR THE RELEASE OF RECORDS

By signing this form, you are authorizing Sexual Violence Response (SVR) to release otherwise confidential information to one or more people whom you designate. Please read carefully. We will gladly answer any questions.

I authorize SVR to: (Check all that pertain)

☐ **Discuss** otherwise confidential information

☐ Transmit a **letter** or treatment **summary** containing my otherwise confidential information I authorize the release of the information specified above to:

_____
_____
_____

This information is released for the following purpose(s):

☐ To facilitate service planning

☐ To provide information relevant to academic and/or housing accommodations

☐ Other:

_____

If you have authorized us to **discuss** confidential information, specify the period during which we may communicate with the person(s) listed above, by checking the appropriate box below:

☐ I authorize ongoing communication unless I revoke this consent.

☐ I authorize communication only until _____ (specify date).

Other restrictions or limitations on information to be released (specify):

_____

☐ No other limitations

I understand that I do not have to agree to release confidential information, and that I may withdraw this consent at any time except insofar as action has already been taken in reliance thereupon. A facsimile of this form will be regarded as valid as the original.

Signature: _____
Name (printed): _____
Date: _____

If not personally known to SVR, student's identity was verified by: ☐ CUID
☐ Photo ID (specify type and number) _____ ☐ Other _____