Salem Academy Counseling Services
Jenny Orr, LPC, NCC
500 E. Salem Ave.
Winston-Salem, NC 27101
Phone: (336) 917-5518 Fax: (336) 917-5340

RELEASE OF INFORMATION

Student Name: _____

Date of Birth: _____

Name of person or agency authorized to **(circle one)** *release*/*receive*/*release and receive* information:

_____

_____

Street Address City State Zip Code

_____

Phone Number Fax Number

I authorize Jenny Orr to *release* / *receive*/ *release and receive* information. Initial Here: ____

I provide consent to the release of the following (check one):

_____ **WRITTEN INFORMATION.** Copies of *medical records* to include medical and/or mental health treatment., letters to the above person(s)/agency summarizing or confirming treatment, etc.

_____ **VERBAL INFORMATION.** I am only authorizing my provider to *speak to* the agency/person/persons listed above. I am not authorizing a release of records.

_____ **WRITTEN AND VERBAL INFORMATION**. I authorize a release of information of *both written information/records and verbal exchange* between Jenny Orr and the agency/person/persons listed above.

Salem Academy and Jenny Orr are hereby released from all legal responsibility or liability for the release of the above-mentioned information. I understand that my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.

Signature: _____ **Date:** _____

Relationship to Student: _____