

**BINGHAMTON UNIVERSITY**  
**UNIVERSITY HEALTH and COUNSELING SERVICES**  
**DIVISION OF STUDENT AFFAIRS**  
<http://www2counseling.binghamton.edu>

P.O. Box 6000  
Binghamton, NY 13902-6000  
607-777-2772  
Fax 607-777-2708

**Instructions:** Form is to be completed by *student (or former student)* requesting information. Given the nature of services provided by this office, a call may be made to the *student (or former student)* to verify information and to explain limits of information shared. This form can be faxed or mailed with appropriate letter explaining request.

## CONFIDENTIAL RELEASE OF INFORMATION

I hereby authorize the University Counseling Center, Binghamton University to release to:

\_\_\_\_\_  
Name and title

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone number and/or Fax number, including area code

information regarding services received for the purpose of:

\_\_\_\_\_  
Name: \_\_\_\_\_  
(please print)

\_\_\_\_\_  
Signature: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_

\_\_\_\_\_  
Current Address: \_\_\_\_\_

\_\_\_\_\_  
Phone # and e-mail address: \_\_\_\_\_

This consent is valid until \_\_\_\_\_ (six months maximum before a new release form is signed).  
(specify date)

I understand that I may only revoke this form by notifying, in writing, the person, department or office authorized by this form to release information. I further understand that, after this date, I will need to sign a new release form should I wish to continue to authorize the release of information.

For more information contact:  
J. Thomas Cousins, Ph.D., Clinical Director  
of Counseling Services at 607-777-2772  
or e-mail at [cousins@binghamton.edu](mailto:cousins@binghamton.edu)