CENTRAL MICHIGAN UNIVERSITY

WAIVER OF COUNSELOR-PATIENT PRIVILEGE
AND RELEASE OF INFORMATION

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Print patient name | Soc. Sec. No. | Date of birth

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Patient's current address | Patient's current phone number

I, being the patient identified above and who has signed below, authorize **CENTRAL MICHIGAN UNIVERSITY** to release the counseling information specified below to the individual(s)/facility(ies)/firm(s) listed below, and hereby waive the counselor-patient privilege as to this information.

RECORDS AUTHORIZED FOR RELEASE:
PLEASE SEE THE ATTACHED SUBPOENA OR
LETTER REQUEST FOR INFORMATION TO BE DISCLOSED

PLEASE RELEASE RECORDS TO:
RECORDS DEPOSITION SERVICE, INC.
P.O. BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248-357-3330 F: 248-357-3337

THE PURPOSE OF THE DISCLOSURE IS:
FOR DISCOVERY BEFORE TRIAL

This disclosure may be revoked in writing at any time up to the time that the records have been forwarded to the specific individual, facility or firm. If this request has not been previously revoked, it will terminate on this specified date, event or condition: ____________________

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Signature of patient | Date

________________ ____________________ ____________________

Signature of witness | Printed name of witness | Date