Ouachita Baptist University
Counseling Services

410 Ouachita, box 3646
Arkadelphia, AR 71998
Phone: (870) 245-5591
Fax: (870) 245-5341

PERMISSION TO COMMUNICATE WITH THE OBU ACADEMIC SUCCESS CENTER

I, _____, on this date, ____/____/_____ hereby grant the OBU Counseling Services Office or the ADA 504 Accommodations Coordinator permission to release/transfer the following information:

_____ Verbal communication with my therapist, _____, or the ADA 504 Accommodations Coordinator, Daniel Jarboe, concerning my counseling experience, my ADA Accommodations or related disability, my therapist's opinions and perspectives on my condition, needs, and/or progress, and pertaining to any information I have discussed or disclosed within that professional relationship.

_____ Confirm my attendance/participation in counseling with my OBU Counseling Center staff therapist or graduate intern_____

_____ This release shall NOT pertain to any information concerning _____
_____

_____ Other: _____

Release above information to:

Name: Office of the OBU Academic Success Center

Client Information:

Student ID# _____ Birthdate: ___/___/___ SSN (Last 4 digits)**: _____**

Phone #: _____ Apt./Residence Hall & room #: _____

Release Expiration Date: ____ 12 months ____4 years ____ none

I understand that I may revoke my consent to release this information by providing written notice to my counselor.

_____ _____

Student/Client Signature Date