

**FLORIDA INTERNATIONAL UNIVERISTY
AUTHORIZATION FOR RELEASE OF RECORDS**

Name of student/client: _____
Student ID#: _____ Student Date of Birth: _____

Florida International University (FIU) has been served with a subpoena asking for your psychological records. (See attached.) FIU will not release these unless you consent or a court issues an order. By your signature below, you authorize the FIU Counseling and Psychological Services and the Office of the General Counsel to release the following documentation contained in my file to the person who issued the subpoena.

By your initial next to each statement, you also acknowledge that the following statements are true and correct. FIU will not release your records unless each statement has been initialed by you.

_____ I understand that I have the right to refuse to sign this authorization.

_____ I understand that I can seek legal counsel to advise me with respect to this signing this authorization.

_____ I understand that, by consenting to the release of these records, I am also waiving any right to obtain a court order for these records.

_____ By consenting to the release of these documents, I release the Florida International University Board of Trustees, Florida International University, the FIU Counseling and Psychological Services Center, the FIU Office of the General Counsel, and their employees from all liability that may arise in the disclosure of the record.

This authorization is for a single time disclosure which is valid for ninety (90) days after the date of my signature as it appears below.

_____ Date: _____
Student Signature

_____ Date: _____
Empowered Representative Signature

_____ Date: _____
(Printed Name of Parent or guardian if individual is a minor)

State of _____
County of _____

Subscribed and sworn to before me this ___ day of _____, 20____ by _____, who is personally known to me or produced _____ as form of identification.

Notary Public, State of _____ (SEAL)