Authorization for Release of Information

I hereby authorize University at Buffalo to provide the information below for the purpose of a referral to the Crisis Services Advocate Program in order to receive support services. This includes the authorization to transmit information electronically. I understand that signing this form will serve only to provide a referral to Crisis Services, and for further release of information regarding my case, additional documents will need to be signed.

I understand signing this authorization is voluntary and I can opt out of services at any time.

Client Name: _____

Safe Phone Number: _____

Safe Email Address: _____

Safe to identify as: Other: _____

Leave Message:

Text:

☐ **I request that a brief description of the reason for this release be relayed to the Crisis Services Advocate upon referral.**

☐ **I request that only my contact information be relayed to the Crisis Services Advocate upon referral.**

Reasons for Referral

- Please provide a brief description of the reason for referral below:

_____
_____
_____
_____
_____
_____

_____

*Please make sure that the client is aware that an Advocate will be in contact with them via phone call within 24-48 hours after referral.

_____ _____

Signature of Client or Authorized Guardian Date

_____ _____

Witness Date