PLEASE INITIAL WHERE APPLICABLE:

1a. ____ I AUTHORIZE THE FACILITY/INDIVIDUALS NAMED TO DISCLOSE/RELEASE THE LISTED INFORMATION TO THE **PETERSON COUNSELING CENTER** (PCC) AND ITS STAFF.

1b. ____ I AUTHORIZE ALL STAFF OF THE PCC & ANY CONTRACTED PROVIDERS AT RINGLING COLLEGE TO DISCLOSE/RELEASE THE INFORMATION BELOW FROM THE RECORDS OF:

2. Name: _____ **Birthdate:** _____
Last First MI Month / Day / Year

3. THIS INFORMATION IS TO BE DISCLOSED/RELEASED TO THE FOLLOWING:

3a. _____ Sarasota Memorial Health Care System
3b. _____ Offices of Student Life
3c. _____ Offices of Residence Life
3d. _____ Office of Advising, Records & Registration Services
3e. _____ Student Learning Center
3f. _____ Student Access Services
3g. _____ Center for Diversity and Inclusion
3h. _____ Office of International Student Affairs
3i. _____ Bayside Behavioral Health (Fax: 941-917-8849)
3j. _____ First Step of Sarasota (Fax: 941-365-4113)
3k.