ILLINOIS EASTERN COMMUNITY COLLEGES

Student Optional Disclosure of Private Mental Health Information

Student ID: ____

Name (please print) ____
(First) (Middle) (Last)

Address____

City_______________________________ State ______________ Zip ______________

Date of Birth (MM/BD/YYYY) ____

Phone (_____) ____

Primary College of Attendance (check one): ❒Frontier ❒Lincoln Trail ❒Olney Central ❒Wabash Valley

As a student at Illinois Eastern Community Colleges (FCC, LTC, OCC, and WVC), I may authorize the disclosure of my private mental health information to the designated individual named below and understand that:

1. my chosen designated individual must be a parent, guardian, or other person, over the age of 18, designated by me to receive certain private mental health information.
2. my signature authorizes IECC to disclose my private mental information, to my designated individual only if a physician, clinical psychologist, or qualified examiner *employed by IECC*, makes a determination that I pose a clear danger to myself, or others, in order to protect me or another person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon myself, or another person.
3. this request will be in effect for the academic year in which request was made (one year from date of signature), and must be renewed annually, by me during the first two (2) weeks of each fall semester.

_____ I **authorize** the disclosure of my private mental health information to the following:

Name:____
Address:____
Phone Number:______________________________________

_____ I **do not authorize** the disclosure of my private mental health information.

___________________________________ ___________________________
Student Signature Date

___________________________________ ___________________________
Student Records Signature Date

BANNER: Entered _____________ (date)