

**COLLEGE OF THE OZARKS STUDENT COUNSELING CENTER**

P.O. Box 17  
Point Lookout, MO 65726  
417.690.3441 or 417-690-2296  
Fax: 417.690.2490

**RELEASE OF INFORMATION**

**Client Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Based upon the information received from the above-named client, in addition to my observations, I believe and confirm to the best of my professional judgment the client is an unaccompanied, self-supporting youth at risk of homelessness after July 1, 2025. This means, after July 1, 2025, the client was not in the physical custody of a parent or guardian, provides for his/her own living expenses entirely on his/her own, and is at risk of losing his/her housing.

Counselor: \_\_\_\_\_

**I, the above-named client, do provide consent to the release of the following (check one):**

\_\_\_\_\_ **Written information.** Copy of only this form to the College of the Ozarks Financial Aid Office.

\_\_\_\_\_ **Written and verbal information.** Copy of only this form to the College of the Ozarks Financial Aid Office and/or verbal confirmation of "homeless status."

**For the purpose of designation of homelessness regarding the application for Federal Student Aid for the 2025-26 school year.**

College of the Ozarks Student Counseling Center is hereby released from all legal responsibility or liability for the release of the above-mentioned information. I understand my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in those Federal and State regulations. I understand I have the right to withdraw this authorization at any time, except for action already taken, and such revocation must be in writing. Further, I understand this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Witness: \_\_\_\_\_ Title: \_\_\_\_\_