INFORMATION RELEASE FORM

I hereby authorize representatives of the Dean of Students Office, Counseling Center, Student Health Center at the College of William and Mary and the physician/therapist below to release/exchange information to/with one another.

[Full Name of Physician(s)/Therapist(s), phone number, and fax number]

Specific type of information to be disclosed/exchanged:

[ ] Assessment [ ] Progress
[ ] Attendance [ ] Recommendations
[ ] Clinical Issues [ ] Treatment Summary
[ ] Drug/Alcohol Issues [ ] All of the above
[ ] Prognosis [ ] Other __________

The purpose and need for such disclosure/exchange:

[ ] Academic Consideration [ ] Family Involvement
[ ] Aftercare Planning [ ] Referral
[ ] Contact with Referral Services [ ] Continued Enrollment
[ ] Continuity with Treatment [ ] All of the Above
[ ] Student Conduct Considerations [ ] Other __________

NAME (Signature): __________________________________________________________

NAME (Print): ______________________________________________________________

TELEPHONE NO. ____________________ STUDENT ID # 93__________________

DATE: _______________________

WITNESS: ________________________

[This release expires 12 months from date listed above unless an earlier date is specified below.]

Updated 1/27/16