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 numbers]

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 Considerations [ ] Family Involvement
[ ] Aftercare Planning [ ] Referral
[ ] Contact with Referral Source [ ] Continued Enrollment
[ ] Continuity of 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 1/18/12

Date of Expiration