

The College of William and Mary
Office of the Dean of Students
Office- Phone: 757-221-2510
Fax: 757-221-2538

MEDICAL CLEARANCE
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(s)/therapist(s) 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:

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Progress |
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Clinical Issues | <input type="checkbox"/> Treatment Summary |
| <input type="checkbox"/> Drug/Alcohol Issues | <input checked="" type="checkbox"/> All of the above |
| <input type="checkbox"/> Prognosis | <input type="checkbox"/> Other _____ |

The purpose and need for such disclosure/exchange:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Academic Considerations | <input type="checkbox"/> Family Involvement |
| <input checked="" type="checkbox"/> Aftercare Planning | <input type="checkbox"/> Referral |
| <input type="checkbox"/> Contact with Referral Source | <input checked="" type="checkbox"/> Continued Enrollment |
| <input checked="" type="checkbox"/> Continuity of Treatment | <input type="checkbox"/> All of the Above |
| <input type="checkbox"/> Student Conduct Considerations | <input type="checkbox"/> Other _____ |

NAME (Signature): _____

NAME (Print): _____

TELEPHONE NO. _____ Student ID #930 _____

DATE: _____

WITNESS: _____

(This release is in effect through the student's degree program at the College.
It may be amended in consultation with the Dean of Students.)