



# WILLIAM & MARY

DEAN OF STUDENTS OFFICE

Office Phone: 757-221-2510

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## Information Release Form

Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

I, the undersigned, hereby authorize \_\_\_\_\_ to release and receive information concerning the above-named person to/from: \_\_\_\_\_

Specific type of information to be disclosed/exchanged:

- |  |  |
|--|--|
| <input type="checkbox"/> Assessment          | <input type="checkbox"/> Treatment Summary |
| <input type="checkbox"/> Attendance          | <input type="checkbox"/> Testing Reports   |
| <input type="checkbox"/> Drug/Alcohol Issues | <input type="checkbox"/> Recommendations   |
| <input type="checkbox"/> Medical Records     | <input type="checkbox"/> All of the Above  |
| <input type="checkbox"/> Mental Health       | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Treatment Progress  |  |

I understand that the information is to be used for:

- |   |   |
|---|---|
| <input type="checkbox"/> Academic Considerations      | <input type="checkbox"/> Family Involvement |
| <input type="checkbox"/> ADA Accommodations           | <input type="checkbox"/> All of the Above   |
| <input type="checkbox"/> Aftercare Planning           | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Contact with Referral Source |   |

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. These records may be released via fax machine, written correspondence, telephone, or in-person communication. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person or agency who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person or agency who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

Name (Print): \_\_\_\_\_

Name (Signature): \_\_\_\_\_

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

Telephone: \_\_\_\_\_

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

Provider Full Name: \_\_\_\_\_

Provider Telephone: \_\_\_\_\_

Provider Fax: \_\_\_\_\_

This release expires in 12 months unless another date is specified: \_\_\_\_\_