William & Mary Counseling Center
McLeod Tyler Wellness Center, P.O. Box 8795
Williamsburg, VA. 23187-8795
Phone: 757/221-3620 Fax: 757/221-3615

CONSENT TO RELEASE INFORMATION

NAME: _____ Student ID #: _____

I, the undersigned, hereby authorize the William & Mary Counseling Center to release and receive information concerning the above-named person to/from:

_____
(Name of Person or Institution)

_____
(Address)

Specific type of information to be disclosed/exchanged:

- ❑ Assessment
- ❑ Attendance
- ❑ Treatment Progress
- ❑ Drug/Alcohol Issues
- ❑ Treatment Summary
- ❑ Testing reports
- ❑ Recommendations
- ❑ Psychological Records
- ❑ All of the above
- ❑ Other _____

I understand that the information is to be used for:

- ❑ Academic Considerations
- ❑ Aftercare planning
- ❑ Contact with Referral Source
- ❑ Family involvement
- ❑ Continuity of Treatment
- ❑ Other _____

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.

I understand that health information disclosed under this authorization might no longer be protected to the same extent as when solely in the possession of the William & Mary Counseling Center. Healthcare entities/providers are bound by HIPAA laws, whereas other entities may have varying standards of confidentiality.

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

Name (Signature): _____

Name (Print): _____

Date: _____

Address: _____

Witness _____