

Information Sent

_____ date

_____ by

College of William and Mary Counseling Center
Room 240 Blow Memorial Hall, 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 and 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:

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Testing reports |
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Psychological Records |
| <input type="checkbox"/> Drug/Alcohol Issues | <input type="checkbox"/> All of the above |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Other _____ |

I understand that the information is to be used for:

- | | |
|---|--|
| <input type="checkbox"/> Academic Considerations | <input type="checkbox"/> Family involvement |
| <input type="checkbox"/> Aftercare planning | <input type="checkbox"/> Continuity of Treatment |
| <input type="checkbox"/> Contact with Referral Source | <input type="checkbox"/> 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.

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

Name (Signature): _____

Name (Print): _____

Date: _____

Address: _____

Witness _____