THE CENTER FOR COUNSELING AND STUDENT WELLNESS
Hobart & William Smith Colleges
91 St. Clair Street, Geneva, NY 14456
Telephone: (315) 781-3388 Fax: (315)781-4455

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

1. Today's date: ______________________

2. I, ____, give permission to
Print first, middle, and last names

3. All Staff of The Center for Counseling and Student Wellness including Brian Mistler, Ph.D.; Meghann Wraight-Steinmetz, Ph.D.; Linda Kondilis, Ph.D.; Maria Saavedra, Ph.D.; Michael Siembor; as well as
____ and
other if desired

4. ____
Name of person or entity *Phone#*

5. ____
Address (if off-campus) *Fax#*

to disclose confidential information about me to each other. The information disclosed may include the following ***(please initial** wherever applicable)*:

6. _____ Treatment summary
7. _____ Diagnosis
8. _____ Treatment recommendations
9. _____ Other: ____

10. _____ Restrictions to release (e.g., directionality): _______________________________

This information will be released for the following purposes *(initial wherever applicable)*:

11. _____ To coordinate efforts to help me.
12. _____ Other: ____.

13. This consent will expire no later than one year from today or on the following date: ______________.

By signing this release form, I acknowledge that I have voluntarily granted the aforementioned permissions. I further understand that I may revoke these permissions at any time by writing to The Center for Counseling and Student Wellness.

____
Signature of Student