

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 Finger, 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. _____ Records for alcohol and other drug treatment
10. _____ Other: _____
11. _____ Restrictions to release (e.g., directionality): _____

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

12. _____ To coordinate efforts to help me.
13. _____ Other: _____

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

Providers receiving information from CCSW are responsible to all applicable laws, for both mental health and substance-related treatment records and information regarding confidentiality and nondisclosure to third parties. 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, except to the extent that the providers have already acted in reliance to it.

Signature of Student

Date