COUNSELING CENTER
Hobart & William Smith Colleges
119 St. Clair Street
Geneva, NY 14456
315-781-3388

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Today's date: ________________________

I, ____,
Print first, middle, and last names

give permission to the Clinical Staff of the HWS Counseling Center, to disclose confidential information to (*initial where applicable*):

_____ the Hobart College Dean's Office.

_____ the William Smith College Dean's Office.

The information disclosed will be based in part on information supplied to Dr. VanLone by my licensed or certified professional mental health treatment provider, and will be limited to the following:

- Summary of the mental health treatment I received while on medical leave from HWS
- Statement of my readiness to resume studies at HWS
- Statement of recommendations relating to the need for any ongoing mental health treatment

This information will be released for the purpose of requesting readmission to HWS.

This consent will expire no later than the following date *(consider allowing for at least two months after the date the counseling center receives information from your treatment provider)*:

__________________________.

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Signature of Student

December 2007 version