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, ____,
Print first, middle, and last names

give permission to the Clinical Staff of the Center for Counseling and Student Wellness to disclose confidential information to (*initial below*):

3. _____the Hobart College dean's Office, the William Smith College dean's Office, and/or the Vice President of Student-Affairs (Robb Flowers) or designee.

The information disclosed will be based on information supplied to the Clinical Staff by my licensed or certified professional mental health treatment provider(s), and will be limited to the following:

- Statement of my participation in mental health treatment 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
- Information about substance abuse/dependence diagnoses or treatment, as is relevant to my request for readmission to HWS.
- Information released will be for the purpose of requesting readmission to HWS.

4. This consent will expire no later than one year from today or on the following date: _____ ____________________ *(consider allowing at least two months after this date for the Center for Counseling and Student Wellness to receive information from your treatment provider)*.

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.

5. ____________________________________ ______________________
Signature of Student *Date*