

COUNSELING CENTER
Hobart & William Smith Colleges
91 St. Clair Street
Geneva, NY 14456
phone 315-781-3388
fax 315-781-4455

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Today's date: _____

I, _____,
Print first, middle and last names

give permission to

Name of counselor

of HWS Counseling Center and

Name of person or entity

Address

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

_____ Treatment summary

_____ Diagnosis

_____ Treatment recommendations

_____ Other: _____

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

_____ To coordinate efforts to help me.

_____ Other: _____

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

Signature of Student

Signature of Counselor