

## Hobart and William Smith Colleges Counseling Center

### Consent to release confidential information to Colleges Administrators and Deans

Last Name:	First Name:	Student ID#
Phone #	Date of Birth:	

***I give my permission to the following persons to exchange confidential information about me:***

Counseling Center Staff:

- ◆ Jennifer Hogan, Director
- ◆ Tasha Prosper, Associate Director
- ◆ Katie Pullano, Counselor
- ◆ Katy Wolfe Kelliher, Counselor
- ◆ Bethany Raymond, Counselor
- ◆ Mary Martini-Hausner, Staff Counselor

HWS Administrators:

- \_\_\_ All Administrators included in list below
- \_\_\_ B.B. Barile, Vice President for Campus Life & Dean of Students
- \_\_\_ Kristen Tobey, Associate Dean of Student Engagement
- \_\_\_ Shelle Basilio-Murray, Associate Vice President of Campus Life
- \_\_\_ Hobart /William Smith Deans or their designee
- \_\_\_ Dr. Stephanie Achilles, Psychiatrist
- \_\_\_ Sarah Mullins, CARE and Campus Life Coordinator
- \_\_\_ Other (s)

**Please also include (initial by the following parties you would like to be included):**

- Hubbs Health Center / Finger Lakes Medical Staff
- Residential Education Professional Staff
- Disability Services
- Other (s) (please print): \_\_\_\_\_

**For the purpose of (check all that apply):**

- Continuity of care/Coordinating my mental health support on campus
- Medical Leave
- Academic Concerns
- Health Review
- Other: \_\_\_\_\_

**Information to be released (check all that apply):**

- Verbal Communication with those listed above
- Treatment summary
- Therapist recommendations
- Record of ***counseling attendance only***
- Other: \_\_\_\_\_

*This consent will expire no later than one year from today, or on the following date:* \_\_\_\_\_

Signature (or authorized signature) \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

***I authorize release of my records in accordance with the specification listed above. A photocopy of this consent shall be valid as the original.***

***Providers receiving information from the CC 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 in writing to the CC, except to the extent that the providers have already acted in reliance on it.***

Rev Dec. 2022