Mount Holyoke College Counseling Service

Authorization for Release of Information

NAME: _____ DATE OF BIRTH: _____

CLASS/YEAR: _____ PHONE: _____

I hereby authorize the Mount Holyoke College Counseling Service staff to disclose information to:

(Please *INITIAL* all that apply)

_____ MHC Care and Support Team (Representatives from Counseling Service, Health Center, Division of Student Life, Athletics, Campus Police, and the Office of Student Success and Advising, who may in turn engage others who are in a position to help or have a need to know)

_____ MHC Professional On-Call staff

_____ MHC Office of Residential Life/Dean of Students Office

_____ MHC Office of Student Success and Advising (Includes Office of Academic Deans, Academic Administrative Board, and AccessAbility Services)

_____ MHC Campus Police

_____ MHC Title IX/Section 504 Coordinator

_____ Holyoke Hospital ER/Social Work Assessment Team (SWAT) and Psychiatric Unit

_____ Behavioral Health Network (BHN)

_____ Other Hospital/Emergency Service: _____ (specify, if known)

_____ Parent/Guardian: _____ Phone: _____

_____ Other: _____ Phone: _____

I wish to release all information ***unless*** specified below:

_____

Two-Way Release

I also hereby authorize _____ to disclose information from my mental health/medical records to the MHC Counseling Service staff.

I understand that relevant information about alcohol and/or other substance abuse, HIV/AIDS, sexually transmitted infections, abortion, or sexual/physical abuse may be disclosed if relevant to my current mental health condition or disposition.

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid until I choose to render it null and void unless an expiration date is filled in here: _____

_____ Date: _____

Student Signature