WELLESLEY COLLEGE COUNSELING SERVICE
CONSENT FORM

1. I,_____ (clients name), DOB ___/___/___ agree and hereby authorize the use or disclosure of clinical information by the Wellesley College Counseling Service in the following manner : _____
_____

2. The following is a list of the person(s) authorized:

   a.) _____ to disclose requested information:
   b.) _____ to receive or use requested information:

   _____
   (name/title)

3. The following is a list of person(s) authorized:

   a.) _____ to disclose requested information:
   b.) _____ to receive or use requested information:

   _____
   (name/title)

4. I understand that I may refuse to sign this authorization.

5. I understand that I have the right to revoke this authorization. If I choose to revoke, I must do so in writing, and provide the revocation to the Director of the Wellesley College Counseling Service.

6. I understand that the information, which is used or disclosed based on this authorization, may be further used and/or disclosed by the person who receives it.

7. I understand that the Wellesley College Counseling Service will not condition treatment on my executing this authorization.

8. I understand that I have the right to a copy of this authorization.

9. This authorization shall expire within a year from the date signed.

_____ _____
Date Client Signature

_____ _____
Date Witness
(If signed by a personal representative, please describe the representative's authority)

_____

WELLESLEY Health Service
Wellesley College
106 Central Street
Wellesley, Massachusetts 02481
(781) 283-2810 Fax: (781) 283-3693

Authorization to Release Medical Records

PATIENT'S FULL NAME: _____
(Indicate maiden/former name, if applicable)

TELEPHONE#:_____**DOB**:_____**CLASS YEAR**: _____

Authorized Release of Protected Health Information

From:

☐ Wellesley College Health Service

☐ Another Provider:
_____
_____

To:

☐ Name, address, telephone, fax
_____
_____
_____

☐ Wellesley College Health Service

Please check information to be released:

_____ Immunization records
_____ Copy of most recent physical exam, including diagnostic test reports (include most recent Pap & Pelvic)
_____ Copies of **ALL MEDICAL RECORDS** from _____ to _____
_____ Other (state specific portions of medical record desired)_____

Unless otherwise revoked this authorization will expire 12 months from date of signature. A copy of this form is available to me upon my request. I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

SIGNATURE: _____ DATE: _____

I understand that my record may contain information in reference to treatment for substance and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, or sensitive information. I agree to its release unless specified otherwise (please explain limitations).

SIGNATURE: _____ DATE _____
Patient/Legal Guardian – Relationship

I understand that my medical record may contain information relating to HIV (AIDS) testing or treatment and I agree to its release.

SIGNATURE: _____ DATE _____
Patient/Legal Guardian – Relationship

THERE IS A $15 FEE FOR COPYING THE ENTIRE MEDICAL CHART AND $10 FEE FOR IMMUNIZATIONS ONLY. PLEASE MAKE CHECKS PAYABLE TO WELLESLEY COLLEGE HEALTH SERVICE.