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 - The Stone Center 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.

_____ _____
Client Signature Date

_____ _____
Witness Date

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

WELLESLEY