

of clinical information by the Welles	be), DOB/ agree and hereby authorize the use or disclosure sley College Counseling Service in the following manner: clinical Study Abroad Clearance (SAC) and status of the SAC
2. The following is a list of the	person(s) authorized:
a.) <u>XX</u> to disclose r	equested information: necessary to complete clearance
b.) <u>XX</u> to receive or	use requested information: necessary to complete clearance
WELLESLEY COL	LEGE COUNSELING SERVICE
3. The following is a list of pers	son(s) authorized:
a.) XX to disclose re	equested information: necessary to complete clearance
b.) XX to receive or	use requested information: necessary to complete clearance
	(name/title)
4. I understand that I may refuse to	sign this authorization.
	to revoke this authorization. If I choose to revoke, I must do so in o the Director of the Wellesley College Counseling Service.
6. I understand that the information, further used and/or disclosed by the	which is used or disclosed based on this authorization, may be person who receives it.
7. I understand that the Wellesley C executing this authorization.	ollege Counseling Service will not condition treatment on my
8. I understand that I have the right	to a copy of this authorization.
9. This authorization shall expire wi	thin a year from the date signed.
Date	Client Signature
Date	Witness
(If signed by a personal re	presentative, please describe the representative's authority)



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: clinical information necessary to complete Study Abroad Clearance (SAC) and status of the SAC
2. The following is a list of the person(s) authorized:
a.) XX to disclose requested information: necessary to complete clearance
b.) <u>XX</u> to receive or use requested information: necessary to complete clearance
WELLESLEY COLLEGE COUNSELING SERVICE
3. The following is a list of person(s) authorized:
a.) XX to disclose requested information: necessary to complete clearance
b.) XX to receive or use requested information: necessary to complete clearance
DEAN'S ADVISORY COMMITTEE
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)



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: clinical information necessary to complete Study Abroad Clearance (SAC) and status of the SAC
2. The following is a list of the person(s) authorized:
a.) XX to disclose requested information: necessary to complete clearance
b.)XX_ to receive or use requested information: necessary to complete clearance
WELLESLEY COLLEGE COUNSELING SERVICE
3. The following is a list of person(s) authorized:
a.) _XX_ to disclose requested information: necessary to complete clearance
b.) XX to receive or use requested information: necessary to complete clearance
HEALTH SERVICES 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)



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: clinical information necessary to complete Study Abroad Clearance (SAC), report status and follow-up
2. The following is a list of the person(s) authorized:
a.) XX to disclose requested information: necessary to complete clearance
b.) <u>XX</u> to receive or use requested information: necessary to complete clearance
WELLESLEY COLLEGE COUNSELING SERVICE
3. The following is a list of person(s) authorized:
a.)XX_ to disclose requested information: necessary to complete clearance
b.) XX to receive or use requested information: necessary to complete clearance
OFFICE OF INTERNATIONAL STUDY 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)



of clinical information by the W	s name), DOB/ agree and hereby authorize the use or disclosure ellesley College Counseling Service in the following manner: clinical plete Study Abroad Clearance (SAC) and status of the SAC
2. The following is a list of	the person(s) authorized:
a.) <u>XX</u> to disclo	ose requested information: necessary to complete clearance
b.) <u>XX</u> to receive	ve or use requested information: necessary to complete clearance
WELLESLEY (COLLEGE COUNSELING SERVICE
3. The following is a list of	person(s) authorized:
a.) XX to disclo	se requested information: necessary to complete clearance
b.) XX to receiv	e or use requested information: necessary to complete clearance
PRESCRIBER	(name/title)
4 1 1 4 14 41 6	
4. I understand that I may refus	e to sign this authorization.
	ight to revoke this authorization. If I choose to revoke, I must do so in ion to the Director of the Wellesley College Counseling Service.
6. I understand that the informa further used and/or disclosed by	tion, which is used or disclosed based on this authorization, may be the person who receives it.
7. I understand that the Wellesle executing this authorization.	ey College Counseling Service will not condition treatment on my
8. I understand that I have the r	ight to a copy of this authorization.
9. This authorization shall expin	re within a year from the date signed.
Date	Client Signature
Date	Witness
(If signed by a perso	anal representative, please describe the representative's authority)



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: clinical information necessary to complete Study Abroad Clearance (SAC) and status of the SAC
2. The following is a list of the person(s) authorized:
a.) XX to disclose requested information: necessary to complete clearance
b.) <u>XX</u> to receive or use requested information: necessary to complete clearance
WELLESLEY COLLEGE COUNSELING SERVICE
3. The following is a list of person(s) authorized:
a.) XX_ to disclose requested information: necessary to complete clearance
b.) XX to receive or use requested information: necessary to complete clearance
THERAPIST
(name/title/Telephone)
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)