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: **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

   _____
   (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)

_____

2/2019

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   DEAN'S ADVISORY COMMITTEE

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   HEALTH SERVICES

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Date Client Signature

_____ _____
Date Witness

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

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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: **clinical information necessary to complete Study Abroad Clearance (SAC) , report status and follow-up**

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WELLESLEY COLLEGE COUNSELING SERVICE

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OFFICE OF INTERNATIONAL STUDY

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   PRESCRIBER_____
   (name/title)

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Date Witness

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2/2019

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   THERAPIST_____
   (name/title/Telephone)

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2/2019