Washington and Lee University
Student Health and Counseling
204 W. Washington St.
Lexington, VA 24450

Student Health Center
T: (540) 458-8401
F: (540) 458-8404

Counseling Center
T: (540) 458-8590
F: (540) 458-8989

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

1. Patient

Name – Last, First M		DOB	W&L Class
Street Address			
City	State	Zip	Phone

2. Release Information FROM

□ W&L Student Health Center
□ W&L Counseling Center
Treatment Provider (if applicable):
_____
□ Other (complete box below):

Name (i.e. Health Facility, Physician, etc.)		
Street Address		
City	State	Zip Code
Telephone #	Fax #	

3. Release Information TO

□ W&L Student Health Center
□ W&L Counseling Center
Treatment Provider (if applicable):
_____
□ Other (complete box below):

Name (i.e. Health Facility, Physician, etc.)		
Street Address		
City	State	Zip Code
Telephone #	Fax #	

4. Information To Be Released (Check All That Apply)

□ Complete Copy of All Records
□ Immunizations
□ Lab Results
□ Progress Notes: all ____
or specified dates _____
□ Attendance/Participation in Counseling
□ Psychotherapy notes
□ Results of evaluations
□ Clinical summary letter or email
□ Verbal clinical summary

□ Other (specify): _____
□ Check here If ONLY Records May Be Released (i.e. conversations, including those intended for clarification or follow-up, are not authorized)

5. Purpose for Disclosure (Check All That Apply)

□ Facilitate coordination of health care
□ Academic Adjustment or Accommodations
□ Personal
□ Other (specify): _____

I understand that I am giving my permission to the above named treatment provider or other named third party for disclosure of confidential health care information, including both records and discussions pertaining to those records, unless otherwise noted in Section 4 above. This consent is not a condition for treatment at the Washington and Lee University Student Health Center or Counseling Center. I also understand that I have a right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or third parties to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

_____ _____
Signature of Patient (or parent/guardian if under 18) **Date**

(Rev. 1/15)