ASSUMPTION COLLEGE
STUDENT DEVELOPMENT & COUNSELING CENTER
500 SALISBURY ST
WORCESTER, MA 01609
(508) 767-7409

WRITTEN CONSENT FOR RELEASE OF INFORMATION

NAME OF STUDENT: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

I do, hereby authorize _____
(name of program making disclosure)

To disclose to _____
(name or program/organization/person to whom disclosure is made)

The following information
____ Summary of Counseling/Psychotherapy Treatment
____ Psychiatric Evaluation
____ Psychological Evaluation
____ Physical Evaluation
____ Other _____

_____

FOR THE PURPOSE(S) OF: _____

_____

I am aware that I may withdraw my consent at any time except to the extent that action has been taken in reliance on this statement of informed consent. I understand that even if I do not withdraw consent, this statement of consent shall automatically expire upon the completion of my studies at Assumption College.

_____
Signature of Student Date

_____
Signature of Witness