**AUTHORIZATION TO DISCLOSE MENTAL HEALTH INFORMATION**

**This release allows the Counseling Center to share information about your treatment in the Center or information obtained from an outside therapist with appropriate academic personnel in order to facilitate a medical withdrawal or a return to campus following a withdrawal. Only relevant information regarding the need to withdraw or the readiness to return will be shared and limitations are noted in the authorization below.**

I authorize the Emmanuel College Counseling Center (CC) to \_\_\_**disclose and/or** \_\_\_**receive** my following mental health information:

Yes No

\_\_\_ \_\_\_ type of professional service (e.g. psychotherapy, medication evaluation/monitoring)

\_\_\_ \_\_\_ dates on which professional services were received

\_\_\_ \_\_\_ impact of current condition on ability to successfully complete classes

\_\_\_ \_\_\_ recommendations for continued treatment or supports

To/From the following person(s) or organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The purpose for which this information may be used is:

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I understand that this authorization is subject to revocation by me at any time by submitting a request in writing to the Counseling Center, and that unless I revoke it this release will be in effect for **1 year** from date of signature unless otherwise indicated on Expiration Date below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date Signed Expiration Date

Client Name (please print) and EC ID Number

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