Bard Counseling Services

I, _____, authorize and consent to consultation and exchange of clinical information between Bard College Counseling Services, and _____ _____.

Clinical information to be shared includes:

- ☐ Presence in treatment, prognosis, brief description of progress and occurrence of relapse.
- ☐ Medical history and physical exams, intake sheet, treatment plan, aftercare plan and discharge summary
- ☐ Other _____

This information is needed for the following purpose(s):

- ☐ To provide ongoing treatment
- ☐ To coordinate treatment efforts with my family/concerned persons.
- ☐ Other_____

CONDITIONS OF AUTHORIZATION

1. This authorization will expire on (insert date) _____/_____/_____
   (or event)_____
2. I may revoke this authorization at any time by notifying Bard Counseling Service, and it will be effective on the date notified except to the extent that Bard Counseling Service has acted upon this authorization

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____

Signature of Parent/Guardian _____ Date _____
(when required)

Bard College - PO Box 5000, Annandale-on-Hudson, NY 12504
Phone: (845) 758-7433 Fax: (845)758-7437

Updated 11/13/15