AUTHORIZATION FOR THE RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION between VCCS and the Health Service

I hereby authorize Dr. Mary Cruser, Vassar Counseling Service staff, Deborah Zale, and Vassar College Health Service staff, to exchange the following information from my previous and current evaluation or treatment.

Specific information requested includes:
Current functioning and treatment plan. Current and past symptoms contributing to need for medication. Information about past and present medication management as well as any related medication side effects that are been reported. Information about future appointments scheduled with Dr. Cruser or other prescriber.

Additional information: ____

____

For the Purpose of: Treatment coordination and medication management

I affirm that this form has been fully explained to me by my therapist/medication prescriber and that I understand the meaning of this release.

I understand that I may revoke this authorization at any time except to the extent that action has been taken on this authorization. If not revoked earlier, this consent **will expire one year from the date of release**.

I further understand that the agency or individual that receives this information, in accordance with State/Federal laws is prohibited from disclosing this information without further consent.

Vassar College cannot guarantee that agencies or individuals receiving this information will act in compliance with these laws.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPPA Privacy Rule.

________________________________	________________________________
Signature of individual authorizing release	**Date of release**
________________________________	________________________________
Print Name	**Vassar Student ID Number**