Health and Wellness Center:
Authorization to Exchange Information

Name: _____ Date of Birth: _____
(Saint Mary's Student's Name)

Phone: _____ Email: _____

I hereby authorize the Health and Wellness Center staff at Saint Mary's College of California to discuss and share my medical and psychiatric information that is pertinent and necessary for my care and welfare with the Saint Mary's College department(s) or person checked below. It is my understanding that the information shared will be kept completely confidential with these department representatives or individuals.

- Academic Advising and Achievement
- Student Disability Services
- Athletics Department (NCAA or Club)
- Counseling & Psychological Services
- Parents
- Other _____
- Tutorial and Academic Skills Center
- Office of Public Safety
- Office of Residence Life
- Office of Student Life
- Women's Resource Center

This is a two way release and I also give consent to the above named individuals to discuss my condition and treatment with the Saint Mary's Health and Wellness Center.

Limitations or comments regarding this consent_____

_____

_____

Signed: (*) _____ Date: _____

Witness: _____ Date: _____

*Valid for one year and may be revoked at any time by written notification from the student to the Health and Wellness Center.