



THE EVERGREEN STATE COLLEGE
OLYMPIA, WASHINGTON

Health Center
The Evergreen State College
2700 Evergreen Parkway NW, Seminar 2110
Olympia, WA 98505
phone: (360) 867-6200, fax: (360) 867-6787

Counseling Center
The Evergreen State College
2700 Evergreen Parkway NW, Seminar 4126
Olympia, WA 98505
phone: (360) 867-6800, fax: (360) 867-5441

RELEASE OF INFORMATION

Student Name _____

Date of Birth _____ Evergreen ID# _____

Name and address of person or agency authorized to (circle one) release/receive/release and receive information:

Name of Agency or Person(s)

Street Address City State Zip Code

Name and address of person or agency authorized to (circle one) release/receive/release and receive information:

Name of Agency or Person(s)

Street Address City State Zip Code

This information may include records of treatment for drug or alcohol dependence, sexually transmitted diseases, or HIV testing results (including AIDS).

I **do not** consent to release of the following records information (check appropriate items):

- _____ Sexually transmitted diseases
- _____ HIV testing results
- _____ Substance Abuse (Drug/Alcohol)

I **do** provide consent to the release of the following (check one):

- _____ **WRITTEN INFORMATION.** Copies of *medical records* to include medical and/or mental health treatment, letters to the above person(s)/agency summarizing or confirming treatment, etc.
- _____ **VERBAL INFORMATION.** I am only authorizing my provider to *speak to* the agency/person/persons listed above. I am not authorizing a release of records.
- _____ **WRITTEN AND VERBAL INFORMATION.** I authorize a release of information of *both written information/records and verbal exchange* between the (circle one) Health Center/Counseling Center and the agency/person/persons listed above.

The Evergreen State College Health and Counseling Centers are hereby released from all legal responsibility or liability for the release of the above-mentioned information. I understand that my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.

Signature of patient/client: _____ Date signed: _____

Signature of witness: _____ Date signed: _____