GOODWIN COLLEGE

Consent to Contact

I hereby authorize the staff/faculty noted below to contact the Goodwin College therapist, either verbally or electronically, to give my contact information so that she may reach out to offer help and/or support to myself in a time of need.

I am allowing the release and exchange with each other of the following: (please check all that apply).

- ☐ Contact and attendance of appointment
- ☐ Results of assessment
- ☐ Clinical progress

_____ _____

Goodwin College Staff/Faculty Printed Name Date

_____ _____

Goodwin College Student Printed Name Date

_____

Goodwin College Student Signature

I understand that no disclosure of my records can be made without my written consent unless otherwise provided for in legal statutes and judicial decision. I also understand that I may revoke this consent at any time except to the extent that action has already been taken upon this release. Unless otherwise specified (expiration date :_____), this authorization expires one year from the date of signing.