



Counseling Services
300 North Washington Street
College Union Building
Campus Box 424
Gettysburg, Pennsylvania 17325 -1400

717.337.6960
www.gettysburg.edu

Form 3

**RELEASE OF INFORMATION
FROM HOME HEALTHCARE PROVIDER
TO GETTYSBURG COLLEGE COUNSELING SERVICES**

Date: _____ Date of Birth: _____

This is to certify that I, _____, give full permission to
(Name of Student)

(Name, phone #, FAX # of healthcare provider)

to release the following information to Gettysburg College Counseling Services:

All relevant information.

This release is effective for one (1) year unless an exception is noted here:

Permission can be revoked by me at *anytime* I choose, by providing notice of the revocation in writing, except to the extent that the person who is to make the disclosure or the person receiving information has already acted upon it.

SIGNATURE OF STUDENT: _____