

ASSUMPTION COLLEGE
STUDENT DEVELOPMENT & COUNSELING CENTER
500 SALISBURY ST
WORCESTER, MA 01609
(508) 767-7409

WRITTEN CONSENT FOR RELEASE OF INFORMATION

NAME OF STUDENT: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

I do, hereby authorize the STUDENT DEVELOPMENT & COUNSELING CENTER

TO DISCLOSE TO: ___ The Office of Student Life

 ___ Completion and results of assessment

 ___ Completion of Anger and Aggression Management Program

 ___ Other: _____

FOR THE PURPOSE OF: _____

I am aware that I may withdraw my consent at any time except to the extent that action has been taken in reliance on this statement of informed consent. I understand that even if I do not withdraw consent, this statement of consent shall automatically expire upon the completion of my studies at Assumption College.

Signature of Student

Date

Signature of Witness