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Consent to Release Information

Client name _____ Date _____

I, _____, consent to release information regarding my counseling, therapy and /or testing with _____

To the following individual (s): _____

Information to be released or exchanged includes (check all that apply):

_____ Discharge and summary _____ Progress Notes
_____ Behavioral Health Treatment Records _____ Medication Records
_____ Case Summary _____ School records

Other (Specify) _____

This authorization shall expire: _____

I understand that I may withdraw my consent at any time. I understand that my health and behavioral health records are protected from being shared under Federal and state laws. I may change this permission. This permission is valid until changed or sixty (60) days after I have completed treatment, whichever is sooner. Once I revoke this permission, no information can be released except as allowed by law. A file copy is as good as the original.

This authorization was explained to me and I signed it of my own free will:

Signature of Client/Parent _____ Date: _____

Signature of Witness _____ Date: _____