Consent for Release of Information

Name: _____ DOB:_____ SSN: _____

Address: _____

Phone Number: _____ Parent or Legal Guardian: _____

I, _____, authorize Clay Community Counseling to:

_____Send _____Receive _____Both Send and Receive

The following Information:

_____ Assessments _____Treatment Plan(s)

_____Diagnosis _____Discharge Report

_____Progress Report _____Other- Specify: _____

To/From:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

The above information will be used for the following purposes:

_____ Continuation of Care _____ Other (please indicate): _____

Unless revoked sooner, this authorization extends until:

_____ One time authorization only

_____ Until I am no longer receiving services with Clay Community Counseling

_____ 6 Months from now

_____ 1 Year from now

_____ Until the following date: _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that all information shared will be held as part of my confidential record.

Client's name (please print):

_____

Client's signature: _____ Date: _____

If client is a minor, parent/guardian's name (please print):

_____

Parent/guardian's signature: _____ Date: _____