Stress Management Family Counseling Center

RELEASE OF INFORMATION CONSENT FORM - Adult

I, ______________________________________ authorize ______________________________________
____

to: ___ (send) ___ (receive) the following information regarding myself ___ (to) ___ (from)
the following agencies or people:

____

Name Address City State Zip Telephone

____

Name Address City State Zip Telephone

( ) Case Notes
( ) Medical Reports
( ) Personality Profiles
( ) Billing

( ) Evaluation
( ) Treatment, Progress and Summary Reports
( ) Entire Record

The above information will be used for the following purpose(s):

( ) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating Files
( ) Billing and Payment
( ) Other (specify)____

Such information is considered confidential and is to be used in the best interest of the above named person. Information may be shared via telephone, facsimile, mail or in person.
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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.

Signature of Client ____ Date ________________

Signature of Parent/Guardian ____________________________________ Date ________________

Signature of Witness ____ Date ________________
(if client is unable to sign)

Signature of Person Informing ___________________________________ Date ________________
Client of Rights

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