Stress Management Family Counseling Center

RELEASE OF INFORMATION CONSENT FORM

Children and Family

I, ____ authorize ____
to: ___ (send) ___ (receive) the following information regarding myself and/or the following persons:

Name____ DOB________________
Name____ DOB________________
Name____ DOB________________

___ (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
( ) 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
( ) 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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