

# There's Hope! Counseling Services

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## CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

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I, \_\_\_\_\_  
(Name of patient) (date of birth) (social security number)

Hereby authorize There's Hope! Counseling Services \_\_\_\_\_ to disclose to \_\_\_\_\_ to obtain from:

Person(s) \_\_\_\_\_ Organization \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Information pertaining to my care and treatment including psychiatric, drug abuse and /or alcoholism records. Information required:

\_\_\_\_ Termination/Discharge Summary      \_\_\_\_ Therapist Evaluations  
\_\_\_\_ Psychiatric/Psychological Evaluation      \_\_\_\_ Treatment Plan / Progress Notes  
\_\_\_\_ Medical History      \_\_\_\_ Psychological Assessment / Testing  
\_\_\_\_ Other (Specify) \_\_\_\_\_

This consent is for the period: \_\_\_\_ A. Beginning \_\_\_\_\_ and ending \_\_\_\_\_.  
\_\_\_\_ B. Duration of Treatment.  
\_\_\_\_ C. \_\_\_\_ months after patient signature.

I understand that my right to confidentiality under Federal law and regulations does not protect any information about suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical or bodily harm, or that any one else is in danger of physical or bodily harm that this information is not protected under Federal Regulation. I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. With this knowledge, I give consent to the release of information in my medical records including any information concerning my identity and release There's Hope! Counseling Services, its agents and employees from any liability in connection with the release of the information contained therein.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_