Community Counseling Center

Release of Confidential Information

Client Name: _____ DOB:_____

Address: _____

I authorize the following Health Care Provider, Attorney, School, Medical professional, etc. to release and/or receive the following confidential information in verbal or written form to CCC.

_____

(Individual, Physician, Clinic, School, etc.)

_____

Address Telephone number Fax Number

Check all that apply

___ Written information, including, but not limited to Assessments, ISPs, Quarterly Reports, and Discharge Summaries

___ Verbal information to discuss case planning and management, including, but not limited to telephone contacts and discussion with other agencies.

___ My (or my child's) most recent report or other records that document routine visits, as required by Medicaid.

___ My (or my child's) most recent psychiatric evaluation or other records that document routine visits.

___ Other: _____

Please fax any written information to the number above and to the attention of: (CIRCLE ONE)

Brian Martin, LPC **Glennys Shouey, LPC** **Alexandra (Sandy) Norton, LPC**
Rose Longworth, LPC **Terry Miller, LPC** **Dena Hollar, LPC**
Charles Richards, Resident in Counseling **Shirley Steward-Jones, Resident in Counseling**
Theresa Patsalos **Other: _____**

Expiration Date: This authorization will expire on _____. Of no date is stated, expiration is one year from the signature date. A photocopy of this signed release waiver is considered valid as the original.

_____ _____

Print name of person authorizing to consent release information. Relationship to Client

_____ _____

Signature Date