Community Counseling Center

Release of Confidential Information

Client Name:_____ DOB:_____

Address:_____

I authorize the following person(s) 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: (check all that apply)

- ☐ **Brian Martin, LPC**
- ☐ **Jamie Hiner, LPC**
- ☐ **Melissa Gnagey, LPC**
- ☐ **Terry Miller, LPC**
- ☐ **Other _____**
- ☐ **Alexis Tuttle, Supervisee in Social Work**
- ☐ **Rose Flory, Licensed Clinical Psychologist**
- ☐ **Brendaly Santiago, Supervisee in Social Work**
- ☐ **Charles Richards, Resident in Counseling**
- ☐ **Shirley Stewart-Jones, Resident in Counseling**

Expiration Date: This authorization will expire on _____. If no other 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

_____
Address Telephone # Date