CONSENT TO RELEASE CLIENT RECORDS/ INFORMATION

Name of Client:_____ Date of Birth:_____

Address: _____

I hereby authorize the following specified individual(s) or organization to **exchange** records or information with _____, my counselor at Restore & Rebuild Counseling. This authorization is limited to information concerning myself which has been acquired in a professional capacity and which may be deemed necessary for the purpose of assessment, treatment, or insurance payment. This release is effective beginning on the date signed below, ending on (date): _____.

Examples of specified individuals or organizations:

- For a specified physician, psychologist, counselor, or mental health facility I authorize release of any medical or psychological records or information.
- For a specified school and any teacher, counselor, or administrator thereof, I authorize release of records or information regarding my school attendance, academic performance and behavior as well as pertinent test results.
- For a specified insurance carrier I authorize disclosure of myself as a client, diagnosis, treatment dates, treatment plan, treatment cost, and progress reviews.
- For a specified pastor, family member, or friend I authorize exchange of information that may be pertinent to my treatment, safety, and emotional well-being.

_____ _____

Name of Individual or Organization Phone Number

_____

Address

_____

City State Zip

This consent may be revoked by the undersigned by providing written notice.

_____ _____ _____

Name of Client (or parent/ guardian if client is a minor) Signature of Client (or parent/ guardian if client is a minor) Date

_____ _____ _____

Name of Client (Print) Signature of Client Date