Union Chapel Counseling Center

4622 North Broadway Ave.
Muncie, IN 47303
(765) 215-3777 / (765) 288-8862

Consent for Release of Confidential Information

I, _____ _____ _____ _____
(Client's Last Name) (First Name) (Middle Name) (Maiden Name)

hereby authorize _____ to request / release the following information concerning me/my child from / to

_____
(Name of Person / Hospital / Agency)

Street Address: _____
City: _____ State: _____ Zip Code: _____
FAX: _____

Expires in 90 days or Time Period: _____ to _____
(Month / Day / Year) (Month / Day / Year)

Information To Be Released:

___ Medication Information
___ Psychological Testing
___ Entire Records
___ Treatment Summary
___ Assessment Information
___ Treatment Plan
___ Discharge Summary
___ Verbal Communication Only
___ Diagnosis
___ Progress Notes
___ Attendance
___ Other:

_____

The purpose for the release of information is: _____
_____

I, the undersigned, understand that I may revoke this consent at any time by giving notice to my counselor. However, I also understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality. **This consent shall expire 90 days from date of signature unless another date is specified**.

To the party receiving this information: This information is disclosed from client records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
(Signature of Client or Authorized Representative) (Date of Signature)

_____ _____
(Signature of Parent / Guardian) (Name of Child)

_____ _____
(Signature of Witness) (Relationship to Client)