CONSENT FOR RELEASE OF INFORMATION

I, _____ _____
(Client Name) (Date of Birth)

request and authorize MHB Counseling to

(please check one) ☐ EXCHANGE with ☐ RECEIVE from ☐ PROVIDE TO

NAME and/or AGENCY _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE _____ FAX _____

information (in written and/or oral form) regarding:

- ☐ Initial Evaluation & Recommendations
- ☐ Treatment Summary & Progress
- ☐ Social History
- ☐ Progress Notes
- ☐ Duration of Treatment
- ☐ Appointment Times/Attendance
- ☐ Other _____
- ☐ Medical History
- ☐ Medical Diagnosis & Assessment
- ☐ Physician Notification
- ☐ Hospital Discharge Summary
- ☐ Academic/Work Performance
- ☐ Financial/Insurance Information

This information is for the purpose of:

- ☐ Assisting with the client's evaluation and treatment
- ☐ Coordinating services between MHB Counseling and person/agency named above
- ☐ Transferring information regarding previous treatment
- ☐ Planning and implementing therapy

I understand this consent will expire on _____ 20_____

The consequences of a refusal to release the information listed above may be inability to:

- ☐ Provide continuity and/or coordination of care
- ☐ Develop a comprehensive assessment and treatment plan
- ☐ Other _____

CONSENT FOR RELEASE OF INFORMATION

I understand that my clinical record to/from MHB Counseling contains Protected Health Information. I understand that I may revoke this consent at any time and that this revocation must be made in writing and received by person releasing information. A revocation does not apply to information already released in response to this authorization. I understand that information disclosed as a result of this authorization may no longer be protected and may be disclosed by person/agency receiving the information. I understand I do not have to sign this authorization and that MHB Counseling will not condition treatment on the signing of this authorization. I authorize the sending/receiving of information to/from MHB Counseling & Person/Agency listed above.

CLIENT SIGNATURE _____ DATE _____

THERAPIST SIGNATURE _____ DATE _____