AUTHORIZATION FOR RELEASE OF INFORMATION

While sessions are confidential, signing this form allows your clinician to collaborate with anyone who may prove helpful to your treatment including but not limited to a loved one, medical doctors, referring agencies, etc.

I hereby give my informed consent to the Clear View Counseling Center to communicate with:

_____

(Name)

_____

(Address)

_____

(Phone/ Fax/Email)

□Treatment Summary
□ Admission Assessment
□ Psychological Evaluation
□ Psychologist Progress Notes
□ Updated Primary Care Referral
□ Outpatient Treatment Report
□ Pertinent Court/ Legal Documents

□Termination/ Discharge Summary
□Social Services Progress Notes
□Medical Information
□Dependent's Treatment/ Care
□Updated Care Referral
□Other (Specify): _____

Purpose of Disclosure:
□Assessment & Treatment
□Discharge Planning

□Forensic/ Attorney Consultation
□Other: _____

Patient Name: _____ DOB:_____

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____