We Belong Counseling, Corp.

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RELEASE OF INFORMATION

Authorization for Release of Information Regarding the protected health information of:

Patient Name _____ I authorize

Provider Name _____

And/or administrative staff to:

( ) Obtain and Release ( ) Obtain only ( ) Release only the information below to/from:

(Name and contact information of person or organization)

_____

_____

_____

( ) Communication/Consultation
( ) Academic & Intelligence Testing Reports
( ) Psychological Testing Results and Reports
( ) Lab Reports and Medical Record
( ) Progress Notes
( ) Entire Record
( ) Summary Reports
( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Continuing Appropriate Treatment or Program
( ) Case Review
( ) Updating Files
( ) Other (specify)

_____ I understand that I may revoke this consent at any time by providing written notice which will be effective for all future protections of privacy. I understand that if I gave my provider previous permission to disclose information to an individual or organization that the revocation will be effective on the date signed above. I have been informed what information will be given, its purpose, and who will receive the information. I hereby release the above parties from all liability arising there from.

Signature of Patient _____ Date_____ Signature of Parent/Guardian _____ Date_____ Name of Child if under 18 _____ Relationship to child ( ) Parent ( ) Legal Guardian _____