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INFORMED CONSENT/AUTHORIZATION for the DISCLOSURE of CLIENT CONFIDENTIAL INFORMATION

_____ _____
Client Name Client DOB

I hereby authorize and consent to the release of my/my child's confidential health information

☐ **From** ☐ **To**

_____ _____
Name of Person or Organization Phone Number

_____ _____
Email Address Fax Number

_____
Address City State Zip

Type of information Requested or to be Released:

_____ Assessment _____ Diagnosis _____ Treatment Plan
_____ Progress Notes _____ Discharge Summary
_____ Other (Be Specific): _____

From treatment dates: _____ **to** _____

Written Form: ☐ Yes ☐ No **Verbal Form:** ☐ Yes ☐ No

Purpose of Information: _____ Treatment _____ Assessment _____ Care Coordination

Other: _____

This consent/authorization will automatically expire 365 days from the date signed unless otherwise indicated. This consent/authorization is subject to written revocation at any time. A photocopy of this document is authentic as original. This information is protected by Federal law confidentiality requirements, is for professional purposes, and may not be provided in whole or in part to any other agency, organization or person other than Brooke & Associates Counseling company, LLC, or as specified above.

_____ _____
Client Signature/Responsible Party Date Witness Signature Date