

# Release of Information & Consent Form

It is important that health care providers work together. As such, I, \_\_\_\_\_, would like your permission to communicate, when necessary, with your medical providers.

**Client Name:**

**DOB:**

**SSN:**

**Phone:**

**Address:**

**City, State, Zip:**

I, \_\_\_\_\_, hereby authorize the release and exchange of information specified below between:

Name/Title or Organization Name (i.e., Psychiatrist or Primary Care Physician)

Clinic Name

Organization/Address

Phone/Fax

and

\_\_\_\_\_  
(Counselor Name)

1501 Crocker St., Suite One  
Houston, TX 77019  
P: 832-209-2222 | F: 713-630-0821

This release of information shall be limited to the following specific types of information:

- |  |  |
|--|--|
| <input type="checkbox"/> Assessment                          | <input type="checkbox"/> Nursing/Medical Information       |
| <input type="checkbox"/> Diagnosis                           | <input type="checkbox"/> Toxicological Reports/Drug Screen |
| <input type="checkbox"/> Psychosocial Evaluation             | <input type="checkbox"/> Educational Information           |
| <input type="checkbox"/> Psychological Evaluation            | <input type="checkbox"/> Discharge/Transfer Summary        |
| <input type="checkbox"/> Psychiatric Evaluation              | <input type="checkbox"/> Continuing Care Plan              |
| <input type="checkbox"/> Treatment Plan or Summary           | <input type="checkbox"/> Progress in Treatment/Notes       |
| <input type="checkbox"/> Current Treatment Update            | <input type="checkbox"/> Demographic Information           |
| <input type="checkbox"/> Medication Management Information   | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Presence/Participation in Treatment | <input type="checkbox"/> Other _____                       |

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: \_\_\_\_\_

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Rachel Eddins in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the patient or someone authorized to act on his/her behalf. I understand that this authorization authorizes the release of all medical records including Psychiatric, Alcohol, Drug Abuse, and AIDS records.

Client Name (Printed)

Client Signature

Date