P.O. Box 59768 . Birmingham, AL 35259 . 205.871.3332

Consent to Release Verbal or Written Information

Counselee Name: ____

Address: ____

Home Phone: ___________________Work Phone: ___________________D.O.B. __________________

I, the undersigned counselee or legal guardian, hereby authorize ______verbal and/or________written information to be released by:

____________________________________ ________________________

(Name of Releasing Party) (Phone Number)

Release To:

Mental Health/ Medical Professional Name:_______________________________Phone:__________________

____________ Address: ____

Initial Here

Clergy/Elder/Lay Counselor Name:______________________________Phone:___________________

____________ Address: ____

Initial Here

Family/Significant Other Name:_______________________________Phone:__________________

____________ Address: ____

Initial Here

Purpose: Diagnostic treatment planning: facilitating & coordinating continuing treatment; discharge & aftercare planning & support; insurance company review; or for the following specified purpose:

____

Expiration Date: _______Six months after discharge _______Other

I understand that, upon my request, I may receive a copy of this release and that the information released may be mental health related. I further understand the above consents can be withdrawn by me, in writing, at any time. I can not, however, hold exception to actions that have taken place before I withdrew my consent.

______________________________ __________________ ________________________

Signature of Counselee or Guardian Date Parent or Legal Guardian