



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 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 I further understand the above consents can be withdrawn by me, in writing, at any time.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