Release of Information

Client Information

Name ____ Date of Birth ______________________

Home address ____ Zip _______________

Phone: (Work)________________ (Home)________________ (Cell)___________________

I authorize Glenview Counseling Group and its associates to release information to and from:

Name _________________________________Company ________________________________

Address ____

Phone: ___________________ Fax: ____________________ Other: ______________________

Regarding any and all of the following information concerning my care. This authorization expires on ___/___/______.

- ☐ In person (verbally)
- ☐ By phone (verbally)
- ☐ By written report—faxed, emailed, or mailed

Check all that apply:

- ☐ Any and all clinical information
- ☐ Intake/assessment
- ☐ Dates of treatment
- ☐ Progress notes
- ☐ Discharge summary
- ☐ Client status and progress report
- ☐ Other _________________________

For the purpose of:

- ☐ Continuity of care
- ☐ Disability determination
- ☐ Evidence of care
- ☐ Aftercare services
- ☐ Reimbursement for treatment
- ☐ Other _________________________

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences:

- ☐ Records in question will not be disclosed
- ☐ My insurance company will not be billed and I will forgo using insurance
- ☐ Other: ____

I understand that I have a right to inspect and copy the information to be disclosed.

I understand that I may revoke this consent at any time by giving written notice, except to the extent that Glenview Counseling Group has already taken action in reliance on it.

____ ________________________

Client's signature (age 12 and older) Date

____ ________________________

Parent/guardian of minor OR of legally disabled recipient Date

____ ________________________

Witness signature Date