CONSENT TO RELEASE/RECEIVE INFORMATION

Client's Name_____
LAST FIRST MIDDLE

I _____authorize Tracy E. Crain, LPC and or its representative to send/receive information to/from the following agencies or people:

Name of Agency or Person _____

Phone Number_____ **Fax Number**_____

Location City County State

Name of Agency or Person _____

Phone Number_____ **Fax Number**_____

Location City County State

Name of Agency or Person _____

Phone Number_____ **Fax Number**_____

Location City County State

The client authorizes the following information to be released:
Client's progress, attendance, discharge, medical records, entire record, counselor impressions, allowing this form to be released, verbally or written (by phone or in person, via electronically, fax, by mail, etc.) including any and all other information.

The above information will be used for the following purposes: facilitate communication, compliance with standards/agencies, continuing appropriate treatment or program, updating charts, determining eligibility for benefits or program transfer of records, and medical records.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the Regulations.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation parole, etc.,) and that in any event, this consent expires automatically one year from the date of discharge from this program.

_____ _____

Client Signature **Date**