



Insight Professional Counseling, LLC

Celeste Daiber, M.Ed., NCC, LPC-S, RPT-S

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Release of Information Consent

I, _____, authorize, Celeste Daiber, M.Ed., LPC-S, NCC, RPT

In regards to (client's name, dob), _____

to: ____ (send) ____ (receive) the following ____ (to) ____ (from) the following agencies or people:

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

- | | |
|---|--|
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological testing results |
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Service plans |
| <input type="checkbox"/> Case notes | <input type="checkbox"/> Summary reports |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results |
| <input type="checkbox"/> Medical reports | <input type="checkbox"/> Written and/or oral communication |
| <input type="checkbox"/> Personality profiles | <input type="checkbox"/> Entire record |
| <input type="checkbox"/> Progress reports | <input type="checkbox"/> Other [specify] _____ |
| <input type="checkbox"/> Psychological reports | _____ |

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review
- Updating files
- Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's signature: _____ Date: ____/____/____

Parent/guardian signature: _____ Date: ____/____/____