VALIANT PATH COUNSELING

RELEASE OF INFORMATION CONSENT FORM

		•
to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released	I, [Name of Patient]	("Patient")
Iname or function of the person(s) or entities to whom information is to be released ("Recipient"). THIS AUTHORIZATION PERMITS THE RELEASE OF THE FOLLOWING INFORMATION: —	hereby authorize [Name of Provider]	("Provider")
[name or function of the person(s) or entities to whom information is to be released ("Recipient"). THIS AUTHORIZATION PERMITS THE RELEASE OF THE FOLLOWING INFORMATION: DIAGNOSIS TREATMENT PLAN DATES OF TREATMENT DATES OF TREATMENT ALL MENTAL HEALTH RECORDS OTHER(PLEASE SPECIFY) I AUTHORIZE THE RELEASE OF THE INFORMATION DESCRIBED ABOVE FOR THE FOLLOWING PURPOSE(S): THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST E IN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)		during the course of my treatment
THIS AUTHORIZATION PERMITS THE RELEASE OF THE FOLLOWING INFORMATION: DIAGNOSIS TREATMENT PLAN PROGRESS TO DATE DATES OF TREATMENT ALL MENTAL HEALTH RECORDS OTHER(PLEASE SPECIFY) I AUTHORIZE THE RELEASE OF THE INFORMATION DESCRIBED ABOVE FOR THE FOLLOWING PURPOSE(S): THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST EIN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)	[name or function of the person(s) or entit	ies to whom information is to be
INFORMATION: DIAGNOSIS TREATMENT PLAN PROGRESS TO DATE DATES OF TREATMENT ALL MENTAL HEALTH RECORDS OTHER(PLEASE SPECIFY) I AUTHORIZE THE RELEASE OF THE INFORMATION DESCRIBED ABOVE FOR THE FOLLOWING PURPOSE(S): THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION MUST E IN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)		("Recipient").
DIAGNOSIS TREATMENT PLAN PROGRESS TO DATE DATES OF TREATMENT ALL MENTAL HEALTH RECORDS OTHER(PLEASE SPECIFY) I AUTHORIZE THE RELEASE OF THE INFORMATION DESCRIBED ABOVE FOR THE FOLLOWING PURPOSE(S): THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST EN IN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)	THIS AUTHORIZATION PERMITS THE F	RELEASE OF THE FOLLOWING
PROGRESS TO DATE DATES OF TREATMENT ALL MENTAL HEALTH RECORDS OTHER(PLEASE SPECIFY) I AUTHORIZE THE RELEASE OF THE INFORMATION DESCRIBED ABOVE FOR THE FOLLOWING PURPOSE(S): THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST E IN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)	INFORMATION	ON:
ALL MENTAL HEALTH RECORDS. OTHER (PLEASE SPECIFY) I AUTHORIZE THE RELEASE OF THE INFORMATION DESCRIBED ABOVE FOR THE FOLLOWING PURPOSE(S): THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST EIN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)	DIAGNOSIS	TREATMENT PLAN
I AUTHORIZE THE RELEASE OF THE INFORMATION DESCRIBED ABOVE FOR THE FOLLOWING PURPOSE(S): THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST EIN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL:	PROGRESS TO DATE	DATES OF TREATMENT
THE SPECIFIC USES AND LIMITATIONS ON THE TYPES OF INFORMATION TO BE RELEASED ARE AS FOLLOWS: I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST EIN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)	ALL MENTAL HEALTH RECORDS.	OTHER(PLEASE SPECIFY)
AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST EIN WRITING. THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)	THE SPECIFIC USES AND LIMITATIONS ON TH	OSE(S): E TYPES OF INFORMATION TO BE
THE AUTHORIZATION SHALL REMAIN VALID UNTIL: (EXPIRATION DATE)	I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION AND THAT ANY MODIFICATION OR REVOCATION OF THIS AUTHORIZATION MUST B	
DATE)	IN WRITIN	G.
SIGNATURE DATE		NTIL:(EXPIRATION
	SIGNATURE	DATE