VALIANT PATH COUNSELING

RELEASE OF INFORMATION CONSENT FORM

I, [Name of Patient] _____ ("Patient")

hereby authorize [Name of Provider] _____ ("Provider")

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
_____ ("Recipient").

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 BE IN WRITING.

THE AUTHORIZATION SHALL REMAIN VALID UNTIL: _____ (EXPIRATION DATE)

SIGNATURE_____ DATE _____