~ Counseling For Serenity, LLC with Brenda L. Huffstutler, MSW, LICSW ~

CONSENT FOR RELEASE OF INFORMATION

This form may not be altered once signed. It is intended to oversee only the release of information between the parties described below.

Client name: _____ Birthdate: _____

I authorize Brenda L. Huffstutler, MSW, LICSW to:

- □ Release information to AND/OR
- □ Receive information from

_____ _____

Specific person or agency Address

_____ (____)_____

City State Zip Phone Number

I authorize the release of the following information (initial each type authorized for release):

_____Social reports
_____Medical reports
_____Medications used in treatment
_____School reports
_____Psychological reports
_____Psychiatric reports
_____Treatment goals/progress
_____Information about drug and/or alcohol use (use separate page)
_____Results of court proceedings (other than expunged records)
_____HIV testing and treatment information (use separate page)
_____Assessments
_____Other - please specify
_____

I understand that I have the right to cancel this consent for release of information at any time except when my therapist has already taken action on it. If I wish to cancel this consent, I need to ask my therapist for instructions. Otherwise, this consent will end one (1) year from the date of my signature. The above information will be used for the following purposes: diagnosis and treatment, coordination mental health and medical care, administration of health care service plans, coordination of family treatment and/or other (please specify):

_____

_____

_____ _____

Client Signature Date

_____ _____

Parent/guardian Signature (required if client is under 18) Date

_____ _____

Therapist Signature Date