

Consent for the Release of Personal Information

Client Name: _____ Date of Birth: _____

Guardian: _____ if applicable _____ Social Security number: _____

Address: _____ complete mailing address with city, state zip _____

Grants permission for:

Agency: _____ Phone: _____

Individual: _____ Fax: _____

Address: _____ complete mailing address with city, state zip _____

to share information regarding my (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Diagnoses | <input type="checkbox"/> Department of Family and Children reports |
| <input type="checkbox"/> Mental health assessment | <input type="checkbox"/> Treatment plan |
| <input type="checkbox"/> Educational history and IEP | <input type="checkbox"/> Communicable diseases |
| <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Psychotherapy notes |
| <input type="checkbox"/> School reports | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> Psychological testing | <input type="checkbox"/> Medical history |
| <input type="checkbox"/> Court reports and orders | <input type="checkbox"/> Probation/parole reports |
| <input type="checkbox"/> Medications prescribed | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Appointment dates/attendance | _____ |

Verbally and/or in writing (circle)

with: Brooke Randolph, LMHC of 447 E. 38th Street; Indianapolis, Indiana, 46205,

for the purpose of (check all that apply) :

- | | |
|---|--|
| <input type="checkbox"/> Continuity of care | <input type="checkbox"/> Facilitating treatment planning |
| <input type="checkbox"/> Condition of a court order | <input type="checkbox"/> Client request |
| <input type="checkbox"/> Other: | |

I understand that information that has been released may be subject to re-disclosure by the recipient and is no longer protected by Brooke Randolph, LMHC. I understand that this authorization may be revoked in writing at any time, prior to the specified expiration date. I understand that unless otherwise specified, this consent form will remain in effect for one year from the date of my signature. I understand and agree that a copy of this form shall be as valid as the original.

Signature: _____ Date: _____

Guardian: _____ Date: _____

Witness: _____ Date: _____