Consent for the Release of Personal Information

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):

__Diagnoses
__Mental health assessment
__Educational history and IEP
__Psychiatric evaluation
__School reports
__Psychological testing
__Court reports and orders
__Medications prescribed
__Appointment dates/attendance
__Department of Family and Children reports
__Treatment plan
__Communicable diseases
__Psychotherapy notes
__Discharge summary
__Medical history
__Probation/parole reports
__Other:
_____

Verbally and/or **in writing** (circle)

with: Brooke Randolph, LMHC of 740 E. 52nd Street, Suite 9; Indianapolis, Indiana, 46205,

for the purpose of (check all that apply) :

__Continuity of care
__Condition of a court order
__Other:
_ _ Facilitating treatment planning
__Client request

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: