Brooke Randolph

740 East 52nd Street, Suite 9
Indianapolis, IN 46205
317-455-LMHC

Referral Consent Form

Name: _____, Date of Birth: _____,

Guardian: _____, Social Security number_____,

Mailing Address: _____

I hereby report that I was referred by an individual that I believe is a client of :

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

and I give permission for Brooke Randolph, LMHC to share with my referral source that he or she is eligible to receive one counseling or coaching session free of charge as a result of referring someone to Brooke Randolph, LMHC. I understand that this may be communicated verbally or in writing to my referral source. I further understand that neither my name, any other identifying information, or any HIPAA protected information will be shared with my referral source or anyone else, either at this time or at any time in the future unless I complete a Consent for the Release of Personal Information form. 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. With this understanding, I sign below in agreement and acknowledge my referral source is: Name: _____.

Signed: _____ Date: _____

Printed Name: _____

Licensed Mental Health Counselor