Optimistic Living Counseling, LLC

Consent to Release Information

I, _____, DOB: _____, authorize _____

to send and receive information about my treatment to the following agency or person:

Name: _____ Agency: _____

Address: _____City: _____ State: _____ Zip:____

Phone: _____ Fax:_____

_____ Academic testing results
_____ Behavior Programs
_____ Case notes
_____ Intelligence testing results
_____ Medical records
_____ Personality Profile
_____ Psychological reports
_____ Psychological testing results
_____ Service Plans
_____ Summary Report
_____ Vocational testing results
_____ Entire records
_____ Progress Reports
_____ Other (specify)

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program
_____ Continuing appropriate treatment or program
_____ Case review
_____ Updating files
_____ Other (specify):
_____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. Information will only be released with a hard copy provided. I understand that a consultation with my therapist is highly recommended before any information is released.

Client's signature: _____Date: _____

Parent/guardian: _____Date: _____

Witness (if client is unable to sign): _____Date: _____

Person informing client of rights: _____Date: _____