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## Consent for the Release of Confidential Information

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I, \_\_\_\_\_, authorize A.J. Garcia, MA, LMFT, QCS (MT 2731) to release and receive information about specific aspects (specified below) of my counseling, beginning on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date) and ending with the completion of services. I understand that, if I so desire, I can terminate this consent at any time, and the termination date will be noted below.

The person to whom the information is to be released is: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

The relationship of this person to me is: \_\_\_\_\_

The purpose of this release is *(check all that apply)*:

- |  |   |
|--|---|
| <input type="checkbox"/> Coordination of Services/Referral | <input type="checkbox"/> Legal Conditions |
| <input type="checkbox"/> Family Support/Involvement        | <input type="checkbox"/> Consultation     |
| <input type="checkbox"/> Other: _____                      |   |

The information to be released is *(check all that apply)*:

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Assessment     | <input type="checkbox"/> Attendance   |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Other: _____ |

Method of Contact *(check all that apply)*:

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Telephone | <input type="checkbox"/> Email        |
| <input type="checkbox"/> Facsimile | <input type="checkbox"/> Other: _____ |

I understand that this release gives my counselor permission to provide privileged information, usually kept confidential, to the person above. This form releases my counselor from liability for the release of the above information.

To the party receiving the information:

This information has been disclosed to you from records whose confidentiality is protected under Federal Law. Federal Regulations (HIPAA, 42 CFR Part 2) prohibit you from making any further disclosure without the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (if minor client) and Date: \_\_\_\_\_

Counselor Signature and Date: \_\_\_\_\_ Date: \_\_\_\_\_