COVENANT
COUNSELING & CONSULTING
EMPOWERING PEOPLE. BUILDING RELATIONSHIPS. CHANGING LIVES.

Release of Confidential Client Information Form

Patient Name: _____ D.O.B _____

I authorize Covenant Counseling and Consulting staff to ☐ **release** or ☐ **obtain** the following information with the Person/Practice/Organization indicated below.

INFORMATION APPROVED TO RELEASE OR OBTAIN:

☐ Intake Note
☐ Treatment Plans
☐ Progress notes
☐ Mental Health Diagnosis
☐ Consult with
☐ Psychological Testing
☐ Psychological Screening
☐ Medical History
☐ Substance Treatment
☐ Mental Health Treatment
☐ Billing Information
☐ **All Clinical Records**
☐ **All Financial Records**
☐ Other: _____

APPROVED PERSON/PRACTICE/ORGANIZATION

Name: _____

Organization: _____

Address: (city, state, zip) _____

Phone Number: _____ Fax Number: _____

Release Records into Client Care: ☐ *Yes* ☐ *No* *Initials:* _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:

☐ Attorney/Legal ☐ Insurance ☐ Doctor ☐ Personal ☐ Other: _____

This consent is valid for six months from signature date. I understand that I will need to sign a new release after this date if I continue to authorize the release of my information. I understand that I may revoke this release at any time by notifying, in writing, Covenant Counseling and Consulting office.

Client Signature: _____Date:_____

Witness Name: _____

Witness Signature: _____Date:_____