McArthur Counseling Center

3201 East Center Street Ext Warsaw, IN 46582 PH 574-267-1700 Fax 574-267-0017

Consent to Disclosure of Information and Records

I,_____ (Date of Birth:_____)

hereby authorize _____

to release my records and reports relating to my appointments beginning with my first appointment on _____. This information is to be given to: _____

_____; for the following purpose, use or need:

- ☐ Coordination of treatment
- ☐ Provision of information to other professionals
- ☐ Other _____

The following information from my records may be disclosed:

- ☐ General Protected Health Information (PHI) (Demographic data, dates of service, diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
- ☐ Psychotherapy Notes
- ☐ Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until six (6) months from date of signature.

_____ _____

Signature of Client Date

_____ _____

Witness Date

Consent By Person Other Than Client

If client is under 18 years of age or otherwise unable to consent, the following must be completed:

I,_____ hereby certify that I am the

_____of the client; that the client is unable to consent because he/she is a

minor,_____years of age or because: _____.

_____ _____

Signature of Parent, Guardian, etc. Date

_____ _____

Witness Date