S·U·N·S·T·O·N·E
COUNSELING

CONSENT FOR RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

I, _____, authorize _____
(Client's Name or Parent/Guardian) (Therapist's Name)

to exchange information about me with:

Name: _____
Address: _____
_____
Phone: _____ Email: _____
Fax: _____

I authorize the individual listed above to use or disclose the following information:
(Please check all that apply.)
_____ Academic Testing Results
_____ Teacher/School Counselor/Psychologist Observations, School & Special Education Documents
_____ Service Plans
_____ Summary Reports
_____ Progress Notes
_____ Documents with Diagnoses, Prognoses, and Recommendations
_____ Evaluations and Reports of Consultants
_____ Medical Reports
_____ Personality Profiles
_____ Billing Records
_____ Psychological Assessment/Reports
_____ Vocational and Career Reports
_____ Other: _____

The above information will be released for the following purposes:
_____
_____

I understand that I may revoke this consent at any time by providing written notice, and that after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that all information shared will be held as part of my confidential record.

Client's Name (please print): _____

Client's Signature: _____ Date: _____

If client is a minor, Parent/Guardian's name (please print): _____

Parent/Guardian's Signature: _____ Date: _____