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### AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Behavioral & Counseling Services by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, \_\_\_\_\_ authorize Behavioral & Counseling Services to:

\_\_\_\_\_ release to:

\_\_\_\_\_ obtain from:

\_\_\_\_\_ exchange with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

the following information pertaining to myself:

\_\_\_\_\_ treatment summary/progress

\_\_\_\_\_ diagnosis

\_\_\_\_\_ other (specify) \_\_\_\_\_

\_\_\_\_\_ history/intake

\_\_\_\_\_ dates of treatment attendance

For the purpose of:

\_\_\_\_\_ evaluation/assessment and/or coordinating treatment efforts

\_\_\_\_\_ other (specify) \_\_\_\_\_

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event listed below:

\_\_\_\_\_

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

\_\_\_\_\_  
Name of Client

\_\_\_\_\_  
Name of Parent/Guardian signing form

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

