

CONSENT FOR RELEASE OR EXCHANGE OF INFORMATION

Patient Name: _____ DOB: _____

Information to Be Released to or Exchanged With:

Name: _____

Address: _____

Information To Be Released/Exchanged:

History and Physical Exam Court/Agency Documents Family Assessment

Discharge Summary Mental Status Education Records

Psychiatric Evaluation Treatment Plans Educational Tests and Reports

Psychological Test Results Progress Notes Attendance Record

Substance Abuse Recovery History Psychosocial Lab Reports

Dates of Hospitalization Medical Records Verbal Communication

Other (specify) _____

I give my permission for the staff of Champions Christian Counseling Center to release any and all information about me to the persons listed above.

Signature: _____ Date: _____

Witness: _____ Date: _____