PARHAM COUNSELING, INC.
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Clinical Director

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CONSENT TO RELEASE OR OBTAIN INFORMATION

Date: _____ Client Name: _____

Date of Birth: _____ Address: _____

Telephone: _____ City, State, Zip: _____

I, _____, hereby authorize Robert W. Parham, MA

_____To RELEASE information as described below to:
_____To OBTAIN information as described below from:
_____To EXCHANGE information as described below with:

Persons or Agency to Release, Obtain, or Exchange information:

Name of Person: _____

Agency or Firm: _____

Address: _____ Telephone: _____

City, State, Zip: _____

Information to be released: (Please check next to appropriate information)

_____Psychological Evaluation/Testing
_____Police Reports
_____Progress Notes/Reports
_____Medical Records
_____Verbal Communication for Continuity of Care
_____Investigating Reports
_____Admissions/Discharge Summaries
_____Treatment Plans
_____Other (specify)_____
_____

I understand that this information is protected under State and Federal confidentiality regulations. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it. Photocopies, or fax copies are to be considered as equivalent to the original. This consent expires upon the occurrence of (date, event, circumstance): _____.

Client or
Legal Guardian: _____ Date: _____

Witness: _____ Date: _____