Counseling Connections ADK

88 Woodruff Street
Saranac Lake, New York, 12983
(518)523-6516

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's Name_____ Date of Request_____

Date of Birth_____ Social Security Number_____

I, _____, hereby authorize Counseling Connections to release and/or receive specified information regarding my treatment or my child's treatment. Information can be exchanged between Counseling Connections and the agency listed below:

_____
Agency Name

_____
Agency Address

_____ Medical Records and Reports
_____ Medications
_____ Diagnosis
_____ Tests and Examinations
_____ Other _____
_____

I understand this information is necessary to evaluate, arrange and coordinate services on my behalf and release the above named parties from liability for the exchange of information between themselves. This release will expire 90 days following my termination of counseling services.

Signature of Client_____ Date_____

Signature of Responsible Party_____ Date_____

Witness_____ Date_____