Meaningful Solutions Counseling & Consulting
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REQUEST TO RELEASE CONFIDENTIAL RECORDS / INFORMATION

I hearby authorize:
Person or facility:____
Address:____
Telephone: ____
To share and/or release information from records about
CLIENT: Name____
Date of Birth ____
Social Security # ___________________________________

Release and disclose information from medical, educational, psychiatric / drug / alcohol records.
For the following purposes (s):

□ **Further mental health evaluation, treatment, or care**
□ **Monitoring Progress** □ **Coordination of Treatment and Support**
□ **Coordination of Payment for Professional Services Rendered**
□ **All of the Above** □ **Other**:_____________________________________

These records concern the time between ________________ and __________________ .

This information to be released is marked by an **X** in the boxes below:

□ **Intake and discharge summaries** □ **Medical History and Evaluation (s)**
□ **Mental Health evaluation (s)** □ **Developmental/Social History**
□ **Progress Notes and Treatment or closing summary** □ **Educational Records**
□ **All of the Above** □ **Other**:______________________________

Select only one:

□ Please forward the records to the address at the top of this form.
□ Please forward the records to the address written above.

I fully understand this request/authorization to release records and information, including the nature of the request and the consequences and implications of their release. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 12 months after the date of client termination unless another date is specified. For reimbursement purposes this authorization shall remain in effect until full reimbursement for services has been received by this therapist.

Specification of the date, event or condition upon which this consent expires: one year from date of last contact.

_____________________________ ________________________ _______
Signature of Client Printed Name Date

_____________________________ ________________________ _______
Signature of Parent/Guardian Printed Name Date

Therapist's Signature: ____

PROHIBITION ON REDISCLOSURE: THIS INFORMATION IS BEING DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY LAW. FURTHER DISCLOSURE OF THIS INFORMATION EXCEPT WITH THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS IS PROHIBITED BY LAW.

□ Copy for patient or parent/ guardian □ Copy for source of records □ Copy for recipient