Benton Street Counseling llc
BSTCOUNSELING.COM

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1030 Kingshighway
Suite A
Rolla, MO 65402
573-458-9920 P

Consent to Release Information and Records

I, _____, (DOB: _____) hereby authorize, _____

to release my records and reports relating to my appointments beginning with my first appointment on

_____. This information is to be given to:

_____

For the following purpose(s):

____ (initials) Coordination of Treatment
____ (initials) Provision of information to other professionals
____ (initials) Other: _____

The following information from my records may be disclosed:

____ (initials) General Protected Health Information (PHI) (Demographic data, dates of service, Diagnosis, psychological evaluation, treatment plan, global assessment of treatment progress)
____ (initials) Psychotherapy notes
____ (initials) Verbal Exchange of PHI

I understand that this authorization may be withdrawn by me at anytime. Revocation of this authorization will not affect any information already released. I hereby certify that I am 18 years of age or older. Unless this form is previously revoked in writing, this release of information will remain in force until twelve (12) months from date of signature.

_____ _____
Client Signature Date

_____ _____
Witness Date

If client is under 18 years of age or otherwise unable to consent, the following must be completed:

I, _____, hereby certify that I am the _____

of the client and that the client is unable to consent because he/she is minor, years of age or because:

_____

_____ _____
Parent/Guardian Signature Date