JOY COUNSELING INC. CONSENT TO RELEASE INFORMATION

Communication between healthcare providers and/or among family members is important to help ensure that you receive comprehensive and quality care; however, your information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and/or medication history. You may revoke this consent at any time, except to the extent that action has already been taken in reliance upon it. In any event, this consent shall expire one (1) year from the date of signature, unless another date is specified.

I, _____, for the purpose of coordinating care, authorize
(Client Name)

_____Kim Clark_____to release information indicated below
(Provider Name)

TO : _____.
(Recipient's name/organization)

Ok for information to be exchanged in between providers Yes No

Please indicate the information you authorize for release to the above named party:

___ Any applicable mental health/substance abuse information

___ Only medical information

___ Other: _____

___ None

I/we have read and understand the above information and give my/our consent. Please note that it is your responsibility to get authorization from the other parent. By signing this document, you are authorizing that both parents are in agreement of releasing information for your child.

_____ _____

Client or Parent/Guardian Signature (if under 18) Kim Clark:

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