CONSENT FOR RELEASE OF INFORMATION

Name of Client _____ S.S. _____

DOB ___/___/____Treatment Dates_____ Parent/Guardian giving consent _____

Address _____

Client Phone#_____ Parent/Guardian Phone #:_____

1. This consent cannot be in effect any longer than one year from my signature date. I can choose to make it expire at an earlier date.
   a. I wish to make it expire in one year initial
   b. I wish to make it expire on the date I have provided, which is earlier than one year: _____ give date initial

2. I authorize (by my initials in the box) a release of my records as indicated:
   a. initial verbally b. initial mailed c. initial secure fax d. initial electronically initial All (a-d)

3. Yes / No (circle one) I authorize unrestricted access to all types of records, as needed.

If unrestricted access is **not** authorized, indicate the type of information to be released . (initial all that apply).
Note: Confidential health and mental health treatment records will not be segregated unless requested*. Special charges may apply for records management requests.

_____ Billing
_____ Counseling/Therapy Sessions
_____ Medications/Medical History
_____ Psychological Reports
_____ Scheduling
_____ Transfer/ Discharge
_____ Treatment Plans
_____* Other (Specify) _____

Release of Information: (Please authorize and address separately all persons/agencies that apply)

By my initials, I request and authorize CornerstoneVision Counseling and/or my therapist to:

initial release to initial obtain from

Person/Agency _____

Address _____

Telephone _____ Fax _____

For the Purpose of _____

I understand and hold harmless CornerstoneVision Counseling and Psychological Services as not liable in regard to the use of information that I have authorized for release or exchange. The State of Indiana (16-39-1-4) restricts consent to release information to the date I have stated. I understand that my consent is terminated when the purpose of the release is fulfilled. I may cancel my consent at anytime by notifying CornerstoneVision Counseling with a written statement requesting such action. To be maintained more than one year, this release must be renewed annually. However, my cancellation does not affect past action already taken with any such information that was released with my consent. I voluntarily authorize disclosure of this information. I understand that the information being released is for professional use only and may not be provided in whole or in part to any other agency or individual other than those stated above. Except as provided under Federal Law 45 CFR 164.524, this information has been released from records protected by Federal Law (45 CFR Part 2) and prohibits further disclosure and/or redisclosure by the recipient of the information. A general release of your mental health records is not sufficient for this purpose. I understand that any disclosure of my mental health records comes with the potential that unauthorized redisclosure by other parties or entities who may receive this information may not be protected by Federal Confidentiality rules. initial

_____ _____
Signature of Client and/or Guardian Date

_____ _____
Signature of Witness Date

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