CONSENT TO EXCHANGE CLIENT INFORMATION

Client Name: ______________________________ **Today's Date:** ________________

Date of Birth: ____________________

I, ____________________________________ hereby authorize the Humanistic Counseling Center
(Client Name or Guardian – Please Print)

Humanistic Counseling Center to exchange information with:

Service Provider: ______________________________

Street Address: ______________________________

City / State / Zip: ______________________________

Telephone: ______________________________

Fax: ______________________________

Information to be released, requested, or exchanged: (Check all that apply or state specific information)

☐ Treatment Summary ☐ Psychological Testing Reports ☐ Progress Notes
☐ Medication Information ☐ Inpatient Information ☐ Medical History
☐ Diagnosis ☐ Intake Information ☐ Case File Summary
☐ Other (Specify) ______________________________

The information is being exchanged, requested, or released for the purpose of: (check all that apply or state reason)

☐ Continuity of Care ☐ Treatment Planning and Implementation ☐ Evaluation
☐ Other (specify) ______________________________

I understand that all exchanged information will remain confidential. However, I am aware that the Humanistic Counseling Center Counseling Center cannot control the recipient's use of the information. I understand that this signed statement is valid for 365 days from the date of my signature. I also understand that I may withdraw my consent at any time in writing.

____
Client's Signature / Date

____
Parent or Guardian's Signature / Date
(if client is a minor)

____
Provider or Staff Member's Signature / Date

Example: Jane Doe, MD, LPCC-S, LISW, Ph.D., MFT, etc.