HUMANISTIC
COUNSELING CENTER

Humanistic Counseling Center
PO Box 24242
Cleveland, OH 44124
P: 216-839-2273
F: 216-896-0735

CONSENT TO EXCHANGE CLIENT INFORMATION

Client Name:_____ **Today's Date:** _____

Date of Birth: _____

I, _____hereby authorize the 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