



**AUTHORIZATION TO RELEASE INFORMATION**

Release of information will not be honored unless an original signed release with all information completed is submitted.

- \* Jerrold F. Beaumont, D.D., Ph.D.
- \* Constance L. Cox, M.A.
- \* Dale D. Eshleman, M.S.
- \* Ruan C. Humphrey, M.A.
- \* Sharon F. Jones, Ph.D.
- \* Barbara R. Keene, Ph.D.
- \* Ginette E. Olsen, Ph.D.
- \* Sarah B. Phillips, M.S.
- \* Wallace A. Reynolds, Ph.D.
- \* Mark S. Sears, M.A.
- \* Michael J. Story, M.
- \* Deborah Wennerstrom, Psy.D.

I hereby authorize \_\_\_\_\_ of the Episcopal Counseling Center to (release or obtain) confidential professional information, including personal, psychological, mental health, substance abuse, AIDS-related information, records, and opinions resulting from my contacts with them.

**INFORMATION IS TO BE -RELEASED TO/ OBTAINED FROM: (circle one)**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/ State/ Zip \_\_\_\_\_

**ATTN:** \_\_\_\_\_

Phone # (\_\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_\_) \_\_\_\_\_

This request specifically includes the following:  Psycho Social History  Psychological Testing  
 Session Summary  Progress Notes  Billing  All records  Other \_\_\_\_\_

Dates to be covered by reports: From: \_\_\_\_\_ To: \_\_\_\_\_

I also authorize \_\_\_\_\_ to communicate with \_\_\_\_\_ regarding all aspects of my treatment, diagnosis and prognosis.

I understand that I have no obligation to disclose the requested information and that I may revoke this consent at anytime by informing any of the above named individuals. This release of information shall be terminated one year from date of signatures, regardless, and any information released may not be re-disclosed without further authorization by signature. The client has been given the opportunity to discuss the possible benefits and disadvantages of releasing the information and a copy of the HIPPA notice of privacy practices is available if requested.

In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

\_\_\_\_\_  
Client, Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Signature Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone #