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**CONFIDENTIAL RELEASE OF INFORMATION**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be Used or Disclosed includes:**

( ) Diagnosis ( ) Consultations

( ) Psychological Evaluation/History ( ) Treatment Plan/Summary

( ) Admission/Discharge Summary ( ) Therapist Recommendations

( ) Presence/Participation in therapy ( ) Progress Notes

( ) Vocational Assessment ( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# I hereby authorize Renew Counseling to:

\_\_\_ Disclose information to: \_\_\_ Receive information from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and title**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address City State Zip Code**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number and/or Fax number, including area code**

# Expiration Date of Authorization

This authorization is effective for 12 months from the date of signature unless revoked or terminated by the patient or the patient’s personal representative.

# Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Renew Counseling.

# Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_