Consent for Release of Information

Client Name: _____

Date of Birth: _____

I hereby authorize and request:

Beth D. Bowers, MSW, LCSW

Beth D. Bowers Counseling, PLLC

1930 North Salem Street, Suite 102

Apex, NC 27523

(919) 368-5900

To release/exchange specified information in my client record:

Name: _____

Address: _____

_____

_____

Phone: _____

Fax: _____

The information to be released/exchanged includes:

☐ *Medical Evaluation* ☐ *Progress Notes* ☐ *Educational Records* ☐ *Psychological Testing* ☐ *Intake Report*

☐ *Closing Summary* ☐ *Treatment Plan* ☐ *Psychiatric Evaluation* ☐ *Other:* _____

I understand this information will be used for:

☐ *Treatment Planning* ☐ *Continuity of Care* ☐ *Evaluation* ☐ *Family Involvement* ☐ *Consultation*

☐ *Other:* _____

The doctrine of informed consent has been explained to me. I understand that there are statues & regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is fully voluntary and is valid for as long as I remain in active treatment with Beth D, Bowers, MSW, LCSW, but not to exceed three years. I understand that I have the right to revoke this authorization at any time, except to the extent that action based on this consent has been taken., by so informing the persons or agencies authorized above in writing, I understand that there is a potential for re-disclosure of this information may not be protected by federal law.

_____ _____

Signature of Client or Parent/Guardian *Date*

_____ _____

Witness *Date*