Arcadia Counseling CENTER

CONSENT FOR RELEASE OF INFORMATION

3610 North 44th Street, Suite 140
Phoenix, Arizona 85018
(602) 218-6901

_____ _____ _____
(CLIENT) (DOB) (SSN, last 4)

I hereby authorize:

to exchange the following information:

- ☐ *Assessment/Evaluation*
- ☐ *Diagnosis*
- ☐ *Prognosis Triage*
- ☐ *Progress Notes*
- ☐ *Discharge Summary*
- ☐ *Psychosocial History*
- ☐ *Treatment Plan(s)*
- ☐ *Other:*_____

with the following person(s) or organization:

Name:
Address:
Phone:
Email:

The purpose of this exchange or disclosure of information:

I understand that I may revoke this release at any time, except to the extent that the practice has taken action in reliance of the consent. Such revocation must be in writing and submitted in writing or e-mail. The consent is valid until revoked; otherwise it will expire on the following date or event: _____ (unless otherwise noted 60 days from issue date). Please be advised this authorization does not protect the information from being disclosed by the recipient.

_____
Date of information issue

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Therapist/Arcadia Counseling Center Date