Consent to Release Information

I, _____, DOB: _____, authorize Beacon Therapy Associates Therapist(s): _____ to send and receive information about my treatment to the following agency or person:

Name: _____ Agency: _____

Address: _____

Phone: _____ Fax: _____

__X_ Verbal case consultations
____ Behavior programs
____ Case notes
____ Intelligence testing results
____ Medical reports
____ Personality profiles
____ Progress reports
____ Psychological reports
____ Psychological testing results
____ Service plans
____ Summary reports
____ Vocational testing results
____ Entire record
____ Other (specify): _____

The above information will be used for the following purposes:

____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Case review
____ Updating files
____ Other (specify): _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's signature:_____ Date: ____/____/____
Parent/guardian signature: _____ Date: ____/____/____
Witness (if client is unable to sign): _____ Date: ____/____/____
Person informing client of rights: _____ Date: ____/____/____

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