COLLABORATIVE COUNSELING TMS

Map Your Journey • Activate Your Brain • Restore Your Hope.

Authorization to Release or Exchange Information

Patient Information

Clients Name: _____

Address: _____

City, State, ZIP: _____

Date of Birth: _____ Phone Number: _____

Other Party

Name of Person/Organization: _____

Address: _____

City, State, ZIP: _____ Phone Number: _____

Information to Be Released

I hereby authorize Collaborative Counseling TMS to (please initial all that apply)

☐Release Information to ☐Gather Information from ☐Exchange Information with

This information may consist of the following (please initial each line to which consent is given):

_____Psychological test reports
_____Psychiatric evaluation reports
_____Periodic reports of psychotherapy
_____Social History Data (family, education, employment, arrest, drugs, and alcohol)
_____Medical Information
_____Other (specify): _____

This information will be used (please initial each line to which consent is given):

_____To determine appropriateness of treatment
_____To develop a diagnosis and treatment plan
_____To facilitate coordination of services
_____At the request of the individual
_____Other (specify): _____

Acknowledgment

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be re-disclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information described above have already taken action in reliance on it. It is automatically revoked 30 days after the termination of the therapeutic relationship or under the following conditions:

This consent is given voluntarily, without coercion. Signing this form is not required to receive treatment/services at Collaborative Counseling TMS.

_____ _____

Signature Date Staff Signature Date