LAKES AREA COUNSELING

Consent for Release of Information

I hereby authorize Lakes Area Counseling to obtain and exchange information regarding:

_____ _____
Client Name Date of birth

The agencies with whom the information will be obtained and/or exchanged include:

(Initial those that apply)

_____ Social Services _____ _____ _____
(County) (Other)

_____ Probation _____ _____ _____
(County) (Other)

_____ School _____ _____ _____
(Name of school) (Other)

The information to be exchanged/released is necessary for the purpose of coordinating comprehensive treatment planning. The required information is:

_____ Medical _____ Diagnostic Assessment _____ Treatment Plans

_____ Educational _____ Progress Notes _____ Discharge Summary

_____ _____
(Other)

I understand that I have a right to refuse to release this information and that my consent is voluntary. This consent may be revoked upon written notice unless the information has already been released. This release expires after one year. I further understand that a photocopy of this authorization will be accepted with the same authority as the original.

Signed: _____ Date: _____
(Parent/Guardian)

Signed: _____ Date: _____
(Client)

Signed: _____ Date: _____
(Staff)