Release of Information

Client Name: _____ DOB: _____

Address: _____

I/We hereby authorize CLEAR SKY COUNSELING SERVICES, PLLC to release to and request from:

_____

Contact Person: _____ Phone Number: _____

Contact Person: _____ Phone Number: _____

Purpose of Request: _____

Documents to be requested or released:

o Monthly Progress Reports

o Mental Health Notes

o Other _____

I/We understand that I/We have the right to inspect and copy the information to be disclosed. I/We understand that I/We may refuse to consent to disclosure prior to the information being released.

I/We understand there will be a copying fee of $.25 per page for information released to myself and/or third parties (exception of government/not-for-profit entities).

I/We have read the above and have had the opportunity to ask questions concerning consent. The consequences, if any, or refusal to consent is, or may be: _____. This consent is valid until _____, 20____ unless revoked by me/us in writing.

I hereby hold CLEAR SKY COUNSELING SERVICES, PLLC harmless from any liability or damages which may arise pursuant to the use of this authorization.

_____ _____

Client Signature/Date (*Required age 12 and older*) Witness/Date

_____

Guardian Signature/Date