Goodenough Counseling and Mediation
Consumer Consent /Authorization To Release Information

I, _____, hereby authorize Goodenough Counseling and Mediation to share information regarding:

(Consumer's name)	*(DOB)*	*(SSN)*	*(Age)*
(Address)	*(City)*	*(State)*	*(Postal Code)*

by [ ] releasing to and/or [ ] obtaining from:

(Name)	*(Relationship to Consumer)*	*(Phone Number)*	
(Address)	*(City)*	*(State)*	*(Postal Code)*

The purpose of this disclosure is: ***(must be completed)***

___ Legal purposes ___ Disability determination ___ To report on-going progress in treatment
___ Insurance purposes ___ Facilitate evaluation / treatment ___ For consumer by consumer request
___ Continuity of Care ___ For participation in treatment
___ Other (specify) _____

The following information is requested or may be released: ***(must be completed)***

_____ Consultation _____ Verification of Attendance _____ Psychiatric/Psychological Evaluation
_____ Clinical Intake _____ Treatment Plans/Updates _____ Medication Management
_____ Diagnosis _____ Monthly/Discharge Summaries _____ Verbal consultation only
_____ Other (specify) _____

I do not authorize disclosure for Marketing, Funding, or Educational Purposes.

I understand that the records and information described above may contain information related to sexually transmitted disease, abuse/neglect history, HIV/AIDS, alcohol and drug abuse treatment and/or mental health, and I specifically authorize the release of this information. I expressly authorize the Goodenough Counseling and Mediation to print, reproduce, publish or otherwise use this information for the purposes noted.

This consent may be ended at any time by the consumer (parent or guardian if a minor). I understand that if I end this consent, I must do so in writing and present my written revocation to the Goodenough Counseling and Mediation. I also understand that the request will not cancel any action that has already been taken as allowed by this consent. Unless the consumer wishes to cancel at an earlier time, this consent will automatically end one year from the date of signature.

_____ _____
Date Signed *Signature of Consumer (if 14 or older, client signature is required)*

_____ _____
Date Signed *Signature of Therapist*

NOTICE TO PARTY RECEIVING INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal and state laws which prohibit making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. This form meets the requirements of Federal Regulation (42CFR, Part 2)