Date Received

RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ____

This form authorizes the release of confidential information of clinical records at Axiom Counseling & Therapy Services, LLC. I authorize my counselor/therapist to disclose and/or obtain information from:

Individual/Agency Name:____

Address:____________________________________City:______________State:_____Zip:_______________

Telephone:___________________________________Fax:_______________________________________

Information that may be released:

_____ a. summary report of all services received

_____ b. consultation for coordination of care

_____ c. copies of any and all records pertaining to services received

_____ d. billing information

_____ e. other____

This consent expires **one year** from the original date signed unless revoked in writing at an earlier time.

I have received, read, and understand the above statements and voluntarily authorize disclosure of confidential information to the individual/agency listed above. I further release the counselors/therapists at Axiom Counseling & Therapy Services, LLC from any liability arising from the release of this information, provided it is done in accordance with applicable law. Federal regulation (42 CFE Part 2) prohibits any further disclosure of this information, except with specific written consent of the person to whom it pertains. Redisclosure of this information is prohibited.

____ _________________________________

Client or Guardian Name (printed) Date

____ _________________________________

Client or Guardian Signature Counselor/Therapist Signature