Blakey Weaver Counseling Center, Inc.
Consent to Release Information

I, _____ authorize Blakey Weaver Counseling Center, Inc., to:

___ disclose information to ___ obtain information from ___ exchange information with

___not disclose my treatment information

_____
(Agency or Name of Person)

_____
(Address) (Phone or fax number)

Date of Birth: _____ Treatment date(s) from _____ to _____

The information to be disclosed is:

_____ All medical records, to include mental health evaluation and treatment, concerns about chemical use, HIV/AIDS and STD information.

OR

The records to be disclosed are marked by an × in the boxes below. Draw a line ~~through~~ the items not to be released.

❑ Assessment ❑ Diagnosis ❑ Educational Information ❑ Psychosocial Evaluation ❑ Presence/ Participation in Treatment	❑ Continuing Care Plan ❑ Treatment Plan or Summary ❑ Progress in Treatment ❑ Current Treatment Update ❑ Billing & Payment History	❑ **HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:** ❑ Do not release HIV-related information. ❑ Do not release reproductive health information. ❑ ❑ Do not release drug and alcohol information.

I authorize the disclosure of records for the following purpose(s) or uses:

❑ Further mental health evaluation, treatment, or care ❑ Rehabilitation program development or services
❑ Treatment planning ❑ Research ❑ Qualification for services or benefits ❑ Other:_____

I understand that I may revoke this consent at any time by written notice. Without an expressed revocation (unless information has already been released) it will expire after twelve months. Release of information on HIV/AIDS, or reproductive health in the case of a minor also requires the minor's signature.

_____
Signature of Patient, Parent or Signature of Guardian Date

_____
Signature of Witness Date