VINE
COUNSELING CENTER

Consent to Release and Obtain Information

I authorize Vine Counseling Center to release/obtain the following information from:

_____

Name of Service Provider and Facility

_____

Address and phone number

Name: _____ **Date of Birth**: _____

Please indicate which information can be shared:

_____ Evaluation Reports/Treatment Plan

_____ Progress Reports/Notes

_____ Individual Education Plan (IEP)

_____ Medical Test Reports

_____ Birth Records/Hospital Reports

_____ Verbal exchange of information Re: evaluation results, treatment goals, progress updates and therapy strategies.

For the purpose of:

_____

This consent is valid from the date of the signature until: _____ I understand that I may revoke this consent at any time and that the above named person authorized to receive this information has the right to inspect information to be disclosed. It has been explained to me that if I refuse to consent to the release of information, there will be no consequences.

_____

Signature Date

_____

Signature of Parent/Guardian Child age 12 years and older

Notice to Receiving Agency/Person: Under the provisions of law you may nor re-disclose any of this information unless the person who consented to this disclosure specifically consents to the re-disclosure in writing.