PARSONS COUNSELING & PLAY THERAPY CENTER

PERMISSION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Parsons Counseling, LLC located at 292 Glades Rd, Suite 8, Berea, KY 40403 (office: 859-428-7862 fax: 859-972-0616) to:

[ ] disclose information to [ ] receive information from [ ] exchange information with

Name(s): _____ Phone #: _____

Business Name: _____

Address: _____
(street) (city) (state) (zip)

Regarding: _____ Client Phone: _____
(Client Name – please print)

Address: _____
(street) (city) (state) (zip)

DOB: _____ SS#: _____

The information to be disclosed is:
[ ] Attendance, behavior, and academic information
[ ] Summary of treatment progress verbal or written
[ ] Physician and medication update
[ ] Progress in counseling
[ ] All Treatment Records
[ ] Any treatment records except client notes
[ ] Other (specify) _____

The purpose of this disclosure is for:
[ ] Further treatment
[ ] Continuity of care
[ ] Billing Insurance
[ ] Other (specify) _____

This consent is effective on _____ and expires on _____.
I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

Client or Legal Guardian of Client Signature: _____ Date: _____

NOTICE: This information has been disclosed from confidential records. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release. (However, there are legal and ethical requirements that counselors take responsible action in those situations as prescribed by law 1) where there is danger of imminent harm to self or others, and 2) in the case of apparent child abuse.)