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### CONSENT TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

CLIENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize Natalis Counseling & Psychology Solutions to:

- |   |  |
|---|--|
| <input type="checkbox"/> RELEASE INFORMATION TO | <input type="checkbox"/> OBTAIN INFORMATION FROM |
| <input type="checkbox"/> VERBALLY EXCHANGE WITH | <input type="checkbox"/> FACSIMILE               |

NAME OF AGENCY: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

PLEASE CHECK SPECIFIC INFORMATION AUTHORIZED TO RELEASE/OBTAIN:

- |  |  |
|--|--|
| <input type="checkbox"/> Intake Summaries                              | <input type="checkbox"/> Medical Reports/Physical Exams<br>(include diagnosis/prognosis) |
| <input type="checkbox"/> Social History                                | <input type="checkbox"/> Psychiatric Evaluations<br>(include diagnosis/prognosis)        |
| <input type="checkbox"/> Treatment Plans                               | <input type="checkbox"/> Lab Reports   |
| <input type="checkbox"/> Therapy Progress Reports                      | <input type="checkbox"/> Progress Reports  |
| <input type="checkbox"/> Discharge and Closing Summaries               | <input type="checkbox"/> Aftercare Plan  |
| <input type="checkbox"/> Psychological Tests/Evaluation Reports        | <input type="checkbox"/> Chemical History/Assessment                                     |
| <input type="checkbox"/> Vocational Evaluation Reports                 | <input type="checkbox"/> Speech <input type="checkbox"/> OT <input type="checkbox"/> PT  |
| <input type="checkbox"/> Admission History and Evaluations/Assessments |  |
| <input type="checkbox"/> School Records                                |  |
| <input type="checkbox"/> Court Report/Custody Studies                  |  |
| <input type="checkbox"/> Other (Specify): _____                        |  |

THE SPECIFIC PURPOSE OR NEED FOR SUCH DISCLOSURE IS:  
\_\_\_\_\_

This authorization will be effective for medical/treatment records generated to the date of signature, and the release of medical records created after the date of signature until the expiration date or the release is revoked by myself in writing. This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires within one year. The consent will last no longer than reasonably necessary to serve the purpose for which it is given. The information disclosed is restricted to the minimum amount necessary to accomplish the intended purpose. The information used or disclosed may no longer be protected once it is used or disclosed in accordance with this authorization.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Parent/Legal Guardian Signature (if applicable) Date

\_\_\_\_\_  
Witness Date