CYPRESS
COUNSELING CENTER, P.C.

CONSENT FOR RELEASE OF INFORMATION

I, _____request & authorize Cypress Counseling Center to exchange with
Client name DOB

_____information (in written and/or oral form) regarding
Name & Agency/Person to Provide/Receive Information

_____
Address State Zip Phone Fax

☐ Initial Evaluation/Recommendations
☐ Duration of Treatment/Program
☐ Psychological Evaluation
☐ Progress Notes
☐ Treatment Summary
☐ Treatment Participation/Progress
☐ Diagnosis & Assessment
☐ Financial/Insurance Information
☐ Medical History
☐ Hospital Discharge Summary
☐ Physician Notification
☐ Academic Performance
☐ Acknowledgement of Referral
☐ Coordination of Care
☐ Social History
☐ Appointment Attendance
☐ School Behavior/Social Skills

This information is for the purpose of:
☐ Transferring information regarding previous treatment ☐ Determining if CCC services are suitable for client's needs
☐ Planning and implementing therapy for client and/or family ☐ Assisting with the client's evaluation & treatment
☐ Coordinating services between CCC and the agency/person named above ☐ Other_____

I understand that this consent will automatically expire on _____ or ☐ upon treatment termination.

1. I authorize you to send/receive copies of these records or reports to/from Cypress Counseling Center, P.C. at the address shown.
2. I understand that my clinical record may contain psychiatric, mental health, developmental disabilities, substance abuse and/or AIDS and/or HIV test results and information.
3. I authorize the release of the information itemized above solely for the purpose indicated on this consent form. Only such information and/or records believed necessary for the purpose expressed above shall be released and disclosed. I may inspect and copy the information to be disclosed.
4. I understand that I have the right to revoke this consent at any time. The revocation must be in writing and received by the person releasing the information. I understand the revocation will not apply to information that has already been released in response to this authorization.
5. I understand that this information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.
6. I understand that information received cannot again be given to another agency or person without my written consent.
7. I understand that I do not have to sign this authorization and Cypress Counseling Center, P.C. will not make treatment contingent upon my decision to sign this authorization.

_____ _____
Client Signature (Parent signature for clients under 14) Date Parent/Guardian (if child is under 18) Date

_____
Cypress Counseling Center, P.C. Staff Signature Date

The consequences of a refusal to release the information itemized above may be the inability to provide continuity and/or coordination of care or develop a comprehensive assessment/treatment plan.

Updated January 2020