CYPRESS
COUNSELING CENTER, P.C.

CONSENT FOR RELEASE OF INFORMATION

I, _____ request and authorize Cypress Counseling Center, P.C. to
Client Name DOB

☐ Exchange with ☐ Receive from ☐ Provide to

_____ information (in written and/or oral form) regarding
(Name & Address of Agency/Person to Provide or Receive Information)

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

This information is for the purpose of:

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

I understand that this consent will automatically expire: ☐ on _____ 20_____.

☐ upon termination of treatment.

The consequences of a refusal to release the information itemized above may be the inability to:

☐ Provide continuity and/or coordination of care
☐ Develop a comprehensive assessment and treatment plan

1. I authorize you to send/receive copies of these records or reports to/from Cypress Counseling Center, P.C. (CCC) 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 signs for clients under age 14) Date Parent/Guardian Signature (If child is under age 18) Date

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