Fairfield County Mental

Wellness Counseling, LLC

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Fairfield County Mental Wellness Counseling, LLC by other individuals or agencies. Such requests should be referred to the original individual or agency.

I ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the Fairfield County Mental Wellness Counseling, LLC to:

\_\_\_\_\_ release to:

\_\_\_\_\_ obtain from:

\_\_\_\_\_ exchange with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

the following information pertaining to myself:

\_\_\_\_\_ treatment summary

\_\_\_\_\_ history/intake

\_\_\_\_\_ diagnosis

\_\_\_\_\_ psychological test results

\_\_\_\_\_ psychiatric evaluation/medication history

\_\_\_\_\_ dates of treatment attendance

\_\_\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the purpose of:

\_\_\_\_\_ evaluation/assessment and/or coordinating treatment efforts

\_\_\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent will automatically expire one (1) year after the date of my signature as it appears below\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date OR

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

\_\_\_\_\_ 6 months OR

\_\_\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Date Witness Date