

Douglas W. Pullin, LCSW, LPC, LLC
Counseling and Therapy

CONSENT FOR RELEASE OF INFORMATION

This form may not be altered once signed. It is intended to oversee only the release of information between the parties described below.

Client name: _____ Birthdate: _____

I authorize Douglas W. Pullin, LCSW, LPC to:

- Release information to AND / OR
 Receive information from

_____ address
_____ (____) _____
City State Zip phone number

I authorize the release of the following information (initial each type authorized for release):

_____ Social reports	_____ Results of court proceedings (other than expunged records)
_____ Medical reports	_____ HIV testing and treatment
_____ Medications used in treatment	_____ information (use separate page)
_____ School reports	_____ Assessments
_____ Psychological reports	_____ Other—please specify
_____ Psychiatric reports	_____
_____ Treatment goals/progress	_____
_____ Information about drug and/or alcohol use (use separate page)	_____

The purpose or need for the disclosure of information is (initial each as relevant):

_____ Diagnosis/evaluation	_____ Education planning
_____ Treatment planning/ongoing trtmt.	_____ Other—please specify
_____ Coordination of services	_____

I understand that I have the right to cancel this consent for release of information at any time except when the my therapist has already taken action on it. If I wish to cancel this consent, I need to ask my therapist for instructions. Otherwise, this consent will end one year from the date of my signature.

_____ date
Client Signature

_____ date
Parent/guardian signature (required if client is under 18)

_____ date
Therapist signature