GUILFORD COUNSELING, PLLC — Consent for Release of Confidential Information

Office (336) 337-5469 Fax: (336) 660-2563
2100 W. Cornwallis Drive Suite O GREENSBORO NC 27408-7036

Client name: _____ Date of Birth: _____

I hereby authorize Guilford Counseling, PLLC to:

❑ Release information to AND/OR

❑ Receive information from

Person or facility: _____

Address: _____

Phone: _____

for the following purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Rehabilitation program development or services

❑ Treatment planning ❑ Research ❑ Other: _____

I authorize the release of the following information:

❑ Intake and discharge summaries _____ ❑ Medical history and evaluation(s) _____

❑ Mental health evaluations _____ ❑ Developmental and/or social history_____

❑ Educational records _____ ❑ Progress notes, and treatment or closing summary _____

❑ Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 1 year from the date on which it is signed.

_____ _____ _____
Signature of client Printed name Date

_____ _____ _____ _____
Signature of parent/guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____ _____ _____
Signature of witness Printed name Date