1229 3rd Avenue North
Phone: 205-319-6459
Fax: 205-847-1199

RELEASE OF INFORMATION

I, _____(Print name of client), give my

Permission to In Touch Counseling Agency, LLC to ____obtain and/or ____release mental health information or other relevant information to the services being received from Business Name, LLC.

_____(Print name of provider)
_____ Address

_____City, State, Zip code

_____ Provider Phone Number

_____ Provider Fax Number

For the purpose of: _____continuity of care_____
(Reason for disclosure – ex.: Treatment planning)

**Note: This form is generally used to allow In Touch Counseling Agency, LLC to speak with other professionals as it relates to your care (i.e. Primary Care Physician, School counselor, Speech Pathologist, Psychiatrists, etc).

I understand that my records are protected under Federal, and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel this consent at any time. This consent automatically expires one year from the date signed.

_____
(Date, event, or condition upon which the consent will expire, not to exceed one year)

_____ _____
Client's signature Date

_____ _____
Parent/Guardian Signature (if applicable) Date

_____ _____
(Witness signature) Date