

**CREATE PATHWAYS COUNSELING, LLC**

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**RELEASE OF INFORMATION CONSENT**

**Client's Name:** \_\_\_\_\_

**I authorize CREATE PATHWAYS COUNSELING, LLC to:**

- Send
- Receive

**The following information:**

- Mental health history and evaluations
- Medical history and evaluations
- Developmental and/or social history
- Educational records
- Progress note, treatment plans and/or discharge summary
- Other

**To/From:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Your relationship to client:**

- Self
- Parent/legal guardian
- Personal representative
- Other

**The above information will be used for the following purposes:**

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for services or program
- Case review
- Updating files
- Other

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45.

The recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary and I may revoke this consent at any time by providing written notice, and after (some states may vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian, have durable power of attorney or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

**Signature:** \_\_\_\_\_

*I consent to sharing information provided here.*

**Date:** \_\_\_\_\_

**Witness signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_