



Consent to Release Information

This consent applies to: _____ DOB: _____
(client) (client's Date of Birth)

I hereby give my informed consent for GENESIS COUNSELING CENTER to talk with and/or release written documentation regarding my treatment to:

(Name of Person/Organization Receiving Information)

(Address, Phone or Fax of Organization, if applicable)

Information to be released:

_____ My Entire Record or Only _____

Consent to Release is valid from date below for twelve months, unless otherwise indicated.

I understand that my records are protected under the Federal HIPPA Laws and under the general laws of my state and cannot be re-disclosed without written consent, except as specifically stated by law.

I understand that I may revoke my authorization to release information at any time in writing and such revocation will be effective on the date of receipt of my revocation. In the event action already has been taken prior to said receipt of revocation, such prior actions are covered by the pre-existing release.

Signature of Patient or Guardian

____/____/_____
Date

Signature of Witness

____/____/_____
Date