

Samaritan Counseling Centers, Inc.
Michigan City, Indiana 46360
(P) 219-879-3283 (F) 219-879-6965
RELEASE OF INFORMATION CONSENT FORM

I, _____, hereby give my permission for the following release of information by my therapist at the Samaritan Counseling Center:

Name of therapist: _____

Check the options that apply:

- To write or call the referring persons as a professional courtesy to let them know that I came for my appointment
- To release information to or request information from the following person/s:

Name of agency, hospital, doctor, or therapist: _____

Mailing Address:

Street

City State Zip

Telephone Fax number

The items covered by this release are checked below:

- Intake Assessment
- Psychological Evaluation
- Treatment Plan
- Discharge Summary
- Psychiatric Evaluation
- Other: _____

This information is being released for the following reasons:

- I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information.
- I understand that the information to be released is protected under state and federal laws that do not permit re-disclosure without my further consent.
- I understand that I may revoke this authorization at any time, except for information that has been disclosed as a result of this authorization prior to its revocation.
- This consent will expire _____ days from the date it is signed.

_____ Signature of Client	_____ Date
_____ Signature of Parent, Guardian, or Authorized Representative	_____ Date
_____ Signature of Witness	_____ Date