WELLSPRING
COUNSELING CENTER OF GREATER LAFAYETTE

# Consent for Release of Information

**Name of Client:** _____ **Date of Birth:** _____

**Parent/Guardian Giving Consent** (if applies): _____

*I hereby authorize the following release of information:*

I authorize unrestricted access to records. (Check one) ☐ YES ☐ NO

**If unrestricted access is not authorized, indicate the type of information which can be released either verbally or in writing.** (Check all those that apply.)

____Psychological Reports
____Psychiatric Examinations
____Medications/Medical History
____Counseling/Therapy Sessions
____Other (Specify) _____

____Legal Records
____Treatment Plans
____Discharge Summary
____Substance Use/Abuse

**Release of Information:** (Please authorize and address separately all persons/agencies that apply.)

**I request and authorize Wellspring Counseling Center** (Check one)
**____ Release to:** **____ Obtain from:**

Person/Agency: _____

Address: _____

City, State, Zip: _____

For the purpose of: _____

I release Wellspring Counseling Center of any and all liability regarding the use of information which I have authorized for release. The State of Indiana (16-39-2-5) restricts consent to release information to a 180 day period following the date of my signature. I understand my consent is terminated when the purpose of the release is fulfilled. I may cancel my consent at any time with a written statement requesting such action. However, my cancellation does not affect past action already taken with any such information that was released with my consent.

It is understood the information released is for professional use only and may not be provided in whole or in part to any other agency or individual other than those stated above. Federal regulation (42-C.F.R. PT.2) prohibits further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____

*Signature of Client or Guardian* *Date*

_____

*Client or Guardian Street Address* *City, State* *Zip*

_____

*Signature of Counselor* *Date*