Ephesians Professional Counseling

Belita Proctor, MS, CRC, LCPC

State Licensed Clinical Professional Counselor, Certified Rehabilitation Counselor
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Consent to Release Clinical Information

Client:_____ DOB:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell:_____

I hereby authorize the release of the following clinical information about me (or about my child or ward) TO and/or FROM Belita Proctor, MS, CRC, LCPC by verbal or written means. **E-mailing clinical information is prohibited**.

____Insurance Verification
____Psychiatric Evaluation
____Psychological Evaluation
____Social History
____Educational Diagnosis
____Academic Records
____Admission/Discharge Summaries
____Summary of Progress
____Laboratory Reports
____Legal Records
____Medications/Changes
____Discharge Plan & medications on discharge
____Other (specify)_____

Organization or person with whom Belita Proctor, LCPC will communicate:

Agency Name:_____

Contact Person: _____

Address: _____

_____

Phone:_____ Fax:_____

• I understand that Belita Proctor, MS, CRC, LCPC cannot be held responsible for re-disclosure of protected health information once it has been released to another party.

• I understand that I may revoke or terminate this authorization by submitting a written request to Belita Proctor, MS, CRC, LCPC otherwise this authorization will be effective for 2 years from the date of signature.

_____ _____ _____

Signature of Client/Legal Guardian | Relationship to Client (if applicable) | Date

_____ _____

Signature of Therapist | Date