**Agape Counseling Services**

**Release of Information Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ herby authorize my information to be shared with:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The below information can be shared:

\_\_\_\_\_(initial) Information needed for billing purposes

\_\_\_\_\_ (initial) Information related to assessment and treatment goals

\_\_\_\_\_ (initial) Substance Abuse information

\_\_\_\_\_ (initial) Emergency Contact Only

\_\_\_\_\_ (initial)Information needed for coordination of care

I understand that my records are protected under the federal and that I must give permission for my records to be released.

I understand that my records are being forwarded to the aforementioned parties and the records may contain information about sensitive information, and/or alcohol and drug use/abuse and authorize the release of these records. I understand that I may revoke this consent at any time except to the extent that action has been taken, and that in any event this consent expires automatically one year from the date of signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_

Printed Name Signature Date