CONSENT TO OBTAIN AND /OR RELEASE

CONFIDENTIAL INFORMATION

Cathy Chalmers, M.A., L.P.C., N.C.C., L.M.F.T. has permission to:

(___) OBTAIN (___) RELEASE Confidential information concerning:

PATIENT NAME ________________________________ Date if Birth _________

Information, when received, will become part of the client's file and, as such, is subject to protection under Federal and State Confidentiality Regulations. The releasing agency/practioner is responsible for deleting any material, comments, or notes it feels must remain privileged from the client.

SPECIFIC MATERIAL BEING REQUESTED/ RELEASED:

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PURPOSE OF THE REQUEST: This material will be used to supplement assessment data. If there is any information you do NOT wish sent to Cathy Chalmers, M.A., L.P.C., N.C.C., L.M.F.T., please indicate: YES NO
If yes, please specify: ____

INFORMATION IS BEING REQUESTED FROM:

Name of Professional/Organization:_______________________________________
Address: ____
City, State, Zip: ____

INFORMATION WILL BE RELEASED TO:

Name of Professional/Organization:_______________________________________
Address: ____
City, State, Zip: ____

My signature indicates that I have read this form and /or have had it read to me in a language I understand, that I understand its contents, am aware of the consequences of such a release, know exactly what information is being disclosed and have had the opportunity to correct or amend the data to make certain it is factual and accurate. I am aware that I may revoke this consent at any time (in writing) or can challenge the content of any released material to which I legally have access. This consent form expires one year from the date of signing unless revoked by me prior to that time. All blank spaces have been filled in except my signature and date.

____ ______________________

(Signature of Client/ Parent / Guardian (Date signed)