

THE PASTORAL INSTITUTE
A Solihten Institute
RELEASE OF INFORMATION CONSENT FORM

I, _____, (Record # _____) hereby give my permission for the following releases of information by the Pastoral Institute Counseling Center:

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, therapist or individual: _____

Mailing address: _____

Street City State Zip

Telephone Fax

The items covered by this release are checked below:

- Intake assessment
- Treatment Plan
- Psychiatric Evaluation
- Psychological Evaluation
- Discharge Summary
- Other

Dates of Service: _____

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
- ❖ This consent will expire **one year** from the date it is signed.
- ❖ PHI (Protected Health Information), once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA.
- ❖ I understand that that I have the right to receive a copy of this release if requested.

Signature of Client

Date

Signature of Collateral

Date

Signature of Witness

Date

REVOCATION OF CONSENT

In revoking consent, I understand that this does not affect any of the ways you used my protected health information while you still had my permission to do so.

Signature of Witness

Date

Signature of Client

Date