THE PASTORAL INSTITUTE
CONGREGATIONAL CARE PROGRAM
RELEASE OF INFORMATION CONSENT FORM

I,_____, hereby give my permission for the following releases of information by my therapist at the Pastoral Institute or Pastoral Institute Affiliate Provider:

Name of Therapist: _____ (To be completed by Pastoral Institute)

Check the options that apply:

☐ To release information requested between a Pastoral Institute Affiliate Provider and the Pastoral Institute, if an Affiliate Provider is working with the above-named person.

☐ To provide scheduling, appointment completion, and billing or invoice information for the above-named person.

☐ To release information **TO:** ☐ or request information **FROM**:

Name of Congregation _____

Phone: _____

Fax: _____

Name of Pastor, Clergy or Authorized Staff: _____

_____

_____

This information is being released for the following reasons: **ATTENDANCE AND BILLING FOR CONGREGATIONAL CARE PROGRAM (CCP) REFERRAL**

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 365 days from the date it is signed. Upon discharge from services, this release will no longer be valid.

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 I have the right to receive a copy of this release if requested.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

REVOCATION OF CONSENT

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

_____ _____
Signature of Witness Date Signature of Client Date

Please fax this completed form to (888) 863-0376.