RELEASE OF INFORMATION

I, _____, hereby authorize Odyssey Counseling, or its designee

_____ to obtain AND/OR release information to:

_____.

The information to be shared is:

___ Diagnosis ___ Drug/alcohol history ___ Treatment summary

___ Attendance ___ Mental status exam ___ Evaluation/assessment

___ Progress ___ Recommendations ___ Discharge summary

___ Prognosis ___ Other:

The purpose for such disclosure is:

___ Continuity of care ___ Aftercare planning

___ Family involvement ___ Referral

___ Contact with referring professional ___ Other:

This consent is subject to revokation at any time, but must be done so in writing by client. Consent will automatically expire one year from the date of signature.

_____ _____
Client Name Date

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
Witness Signature Date

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