***Brooke & Associates***

***Counseling Company, LLC***

***5545 N. Oak Trafficway, Suite 3***

***Kansas City, MO 64118***

***Fax (816)569-6797***

**INFORMED CONSENT/AUTHORIZATION for the DISCLOSURE of CONFIDENTIAL INFORMATION**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MM/DD/YYYY

Name at time of services, if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Services, if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A SEPARATE FORM IS REQUIRED FOR EACH PERSON OR AGENCY**

I hereby authorize and consent to the release of confidential information to/to be received from:

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

Name of Person or Organization

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

Address of Person or Organization

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

Phone Number & Fax Number (if available)

**TYPE OF INFORMATION REQUESTED OR TO BE RELEASED:**

*PLEASE INITIAL*

\_\_\_\_\_ Chemical Dependency/Substance Abuse Records

\_\_\_\_\_ Diagnostic Interview and Mental Status Examination Please Note: In most cases, authorizing

\_\_\_\_\_ Discharge Summary disclosure is voluntary. You can refuse

\_\_\_\_\_ Medications Prescribed and/or Medication Response to sign this authorization. You will be

\_\_\_\_\_ Progress Notes/Clinical Record refused treatment if you refuse to sign

\_\_\_\_\_ Progress Report and Recommendations and care is mandatory by the Courts,

\_\_\_\_\_ BioPsychoSocial Evaluation Corrections, Employee Assistance Program,

\_\_\_\_\_ Psychological Testing and Evaluation Military or the Juvenile Justice System.

\_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_ Referral Information

\_\_\_\_\_ School Records/Grades/IEP Information

\_\_\_\_\_ Verbal Information Regarding Treatment Only

\_\_\_\_\_ Other (Be specific) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR DISCLOSURE AND REQUEST FOR INFORMATION:**

*PLEASE INITIAL*

\_\_\_\_\_ Continuity of Care and Treatment

\_\_\_\_\_ Other (Be specific) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent/authorization is subject to written revocation at any time, except to the extent that action has already been taken in reliance upon this consent. This consent/authorization will automatically expire 365 days from the date signed. A photocopy of this document is authentic as original. It is further understood that the information is released for professional purposes only and may not be provided in whole or part to any other agency, organization or person other than Brooke & Associates Counseling Company, LLC, or as specified above.

I have read this form or have had it read to me and understand its contents. I understand that the information to be released may be of a psychiatric nature.

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

Client Signature Date Signature of Client’s Authorized Representative Date

If Signed by Authorized Representative, describe relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE TO RECIPIENT OF INFORMATION:**

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. You are prohibited from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.