

Counseling Center of Montgomery County

212 Conroe Drive
Conroe, TX 77301

www.CounselingCenterMC.com

CCMC@CounselingCenterMoCo.com

(936) 760-1880 Office

(936) 760-2915 Office

(936) 760-9101 Fax

AUTHORIZATION / REQUEST TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize:

Person / Agency: _____

Address: _____

Phone Number: _____

Email Address: _____

To ___ (send) ___ (receive) information of records about:

Client name: _____

If a minor Parent's name and
Relationship: _____

Date of birth: _____

___ (to) ___ (from)

Person / Agency: Counseling Center of Montgomery County

Address: 212 Conroe Drive

Phone Number: 936-444-3546

Email Address: CCMC@CounselingCenterMoCo.com

For the following purpose: Treatment Planning / Assessment

This release is valid from _____ to _____.

The information to be disclosed is marked by a check below:

Academic testing results

Behavior programs

Case notes

Intelligence testing results

Medical reports

Personality profiles

Progress reports

Psychological reports

Psychological testing results

Service Plans

Summary reports

Entire Record

Other (specify) _____

HIV related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: _____ do not release.

I have had this form explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent an action based on this consent has already been taken. This consent will expire automatically 1 year from the day on which it is signed, or upon fulfillment of the purpose stated above or otherwise agreed upon.

Client Signature

Date

Parent or Representative Signature

(relationship)

Date