Counseling Center of Montgomery County

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(936)760-1880 Offc
(936)760-9101 Fax

REFERRAL AND CONSENT TO RELEASE INFORMATION

From: _____

To: Counseling Center of Montgomery County

Name of Client(s):			**Gender:** **Male** **Female**
Address:			
City:		**State / Zip:**	
Cell Phone:	**Home Phone:**	**Work Phone:**	
Email Address:		**Date of Birth:**	**Age:**
Social Security #:			
Referring Representative:			
Email Address:		**Phone Number:**	

***If referring for family or CoParent counseling, please complete a form for each family member.**

Requested Services:

Group Therapy *Certificate of Completion available upon request	
Substance Recovery	
Alcohol Recovery	
Anger Management	
Conflict Resolution	
Coping Skills	
Healthy Relationships	
Divorce Recovery (Adults / Teens / Kids)	
Parent Class for Divorcing families	
Extended Parent Class for Divorcing Families	
Productive Parenting Classes	
Extended Productive Parenting Classes	
Blending Your Family	

(please check all that apply)

Assessments	
Substance / Alcohol Abuse	
Anger Management	
Mental Health Evaluation	
Custody Evaluation	
Other:	
Counseling Services	
Individual Counseling	
CoParent Counseling	
Family Counseling	
Parent Facilitation	
Other:	

I authorize the Counseling Center of Montgomery County and my referring representative, identified on this form, to exchange my information and release my entire record throughout my treatment and/or representation.

Client Signature _____ Printed Name _____ Date _____

Referring Representative _____ Printed Name _____ Date _____

*Most insurances accepted, but some fees may apply