Peace of Mind
Counseling Centers

# Authorization for the Release or Exchange of Information

Patient Name: _____ Date: _____

Authorization to:

___ Release ___ Exchange

Information to be released or exchanged with:

_____

(Name of Person or Organization)

Information to be released or exchanged:

___ Social History/Clinical Interview
___ Psychological Testing
___ Dates of Treatment
___ Treatment Plans
___ Diagnoses
___ Educational Records
___ Attendance Record
___ Medical Records
___ Discharge Summary
___ Chemical Dependency History
___ Mental Status
___ Progress Notes
___ Crisis Intervention Reports
___ Educational Tests/Reports
___ Comprehensive Treatment Summary
___ Other (Specify): _____

_____ _____

Patient/Guardian Signature Date Signed

_____ _____

PMCC Staff Signature Date Signed