2803 Boilermaker Court, Suite 1C
219-286-7043 (O) 219-246-4655 (F)
Valparaiso, IN 46383

Request/Consent to Release Confidential Information

I hereby authorize mutual release of information between Aspire Counseling Services and:

Person/Facility	
Address:	
Phone/Fax:	
From health records about (Name):	
Date of Birth (MM/DD/YYYY):	

For the following purpose(s):

	Further mental health evaluation, treatment, or continuity of care		Consultation or Coordination of Care
	Rehabilitation program, development, or services		Treatment Planning
	Research		Other

Specific or approximate date(s) of service_____
The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them.

	Medical History, Evaluations, or test results.		Mental Health evaluations
	Developmental and/or Social History		Educational Records
	Intake and discharge summaries		Progress Notes, and/or Treatment Notes/Closing Summary
	Other:		
	Please forward the records to the address in the letterhead at the top of this form.		
	Please forward the records to the address written above.		
	Please consult by telephone.		

I understand and or have had explained to me this request and consent for release of confidential records and information, including the nature of the records, their contents and the implications or consequences of their release. I understand I may withdraw my consent prior to the time information is actually shared. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

	Authorizing a one-time release		Authorizing ongoing consultation
Client Signature & Date		Printed Name	
Parent/Guardian Signature & Date		Printed Name and Relationship	
Witness Signature & Date		Printed Name	