Pastoral Counseling Services of the South Shore

17 Church Street, P.O. Box 2306, Hanover, MA 02339
781-826-0011 (P) 781-826-0012 (F)

RELEASE OF INFORMATION CONSENT FORM

I,_____ _____, hereby give my permission for the following releases of
Client name date of birth

information by my therapist at the Pastoral Counseling Services of the South Shore.

Name of therapist:_____

Check the options that apply:

☐ To write or call the referring persons as a professional courtesy to let them know that I came for my appointment

☐ To release information **to** ☐ or to request information **from** the following person/s:

Name and Address of agency, hospital, doctor, or therapist: _____

_____

_____

The items covered by this release are checked below:

☐ Intake assessment ☐ Psychological evaluation

☐ Treatment Plan ☐ Discharge summary

☐ Psychiatric evaluation ☐ Other: _____

This information is being released for the following reasons:

_____

_____

☐ I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information.

☐ I understand that the information to be releases is protected under the state and federal laws that do not permit re-disclosure without my further consent.

☐ I understand that I may revoke this authorization at any time, except for the information that has been disclosed as a result of this authorization prior to its revocation.

☐ I understand that this authorization will expire two years from my last date of service visit.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Authorized Representative Date

_____ _____
Signature of Witness Date