Client Release Form

International Center for Biblical Counseling of Indiana

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL CLIENT RECORDS

THIS AUTHORIZATION AFFECTS YOUR LEGAL RIGHTS.
PLEASE READ IT CAREFULLY!

CLIENT NAME_____DATE OF BIRTH_____

ADDRESS_____CITY_____

STATE_____ZIP CODE_____

TELEPHONE_____

I HEREBY AUTHORIZE:

[ ] RELEASE TO AND/OR [ ] RECEIVE FROM

NAME_____

ADDRESS_____CITY_____

STATE_____ZIP CODE_____

COPIES AND/OR VERBAL COMMUNICATION OF CLIENT RECORDS AS FOLLOWS:

[ ] No limits. Please send and/or communicate any and all information contained in my client record (includes but is not limited to consultation reports, dictations, records and notes received from other healthcare providers).

[ ] Do not release the following information contained in my client record (please specify).

_____

_____

I ACKNOWLEDGE THAT I HAVE READ, FULLY UNDERSTAND AND VOLUNTARILY SIGNED THIS FORM

_____ _____
SIGNATURE OF CLIENT (PARENT/GUARDIAN IF MINOR) DATE

_____ _____
SIGNATURE OF WITNESS DATE

*This authorization expires in 90 days or may be revoked at the client's written request.

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