WE CARE COUNSELING, INC.

Consent for Release of Information
7300 Whipple Ave NW Suite 2 · North Canton, OH 44720
Phone: 330-305-9100 Fax: 330-305-9103

CLIENT'S FULL NAME: _____ DOB: _____ /_____ /_____

PARENT OR GUARDIAN: _____

I give permission for We Care Counseling, Inc. and the following agency(s) to exchange, give, and receive information regarding service delivery planning for the purpose of securing, coordinating, and/or providing services for the above named person.

AGENCY	CONTACT PERSON	PHONE #	FAX #
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INFORMATION TO BE RELEASED:

_____ Diagnostic Assessment and Treatment Plan	_____ Attendance (including cancellations, missed)	_____ Discharge Summary
_____ Assessments/Evaluations/Testing	_____ IEP, attendance, behavior and grades	_____ Medical History and Medications
_____ Psycho/Social History	_____ Recommendations	_____ Psychiatric Evaluations
_____ Ongoing Communications to Facilitate Services	_____ Progress Notes	

_____ Other _____

❑ I do not request any restrictions on the above release: (please initial) _____

❑ Please describe any restrictions on the above releases: _____

_____

This authorization shall be enforced and effective until _____ at which time this authorization to use or disclose protected health information expires. I understand that I have the right to increase or decrease the amount of time this authorization is in effect. My initials _____ indicate my agreement to the terms of this authorization exceeding the six month time limit imposed by O.A.C.5122-27-08. I also understand that I may cancel this consent for release of information at any time by stating so in writing with the date and my signature. The revocation does not include any information which has been shared between the time I gave permission to share information and the time that it was canceled.

I understand the records hereby released may contain information pertaining to the diagnosis of, or treatment for a psychiatric/emotional condition; or drug or alcohol, HIV/AIDS or AIDS related conditions and/or other communicable diseases and I hereby expressively consent to the release of such.

I understand that my signing or refusing to sign this consent will not affect public benefit or services for which I'm eligible.

_____	_____	_____ /_____ /_____
SIGNATURE OF CLIENT	PRINT NAME OF CLIENT	DATE
_____	_____	_____ /_____ /_____
SIGNATURE OF PARENT/GUARDIAN	PRINT NAME OF PARENT/GUARDIAN	DATE
_____	_____ /_____ /_____	
WITNESS	DATE	

Notice: to any agency receiving any information due to this release, you are receiving information that according to federal law (reg. 42 CFR, Part 2) and may not be further disclosed except as authorized by a court order (i.e. incidents of suspected child abuse and neglect). The general release of information is not significant for this purpose. The information disclosed by this release is done so from records protected by federal law. Violation of federal law is a crime and may be reported to the US district attorney.